ac.care, Murraylands, Final Report: Aspire Child Development and Wellbeing Program.

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Contents

Section one

Introduction

The evaluation of one of the programs provided by the Communities for Children initiative (CfC) is presented here. This ac.care Murraylands commissioned report is divided into five sections. The first section presents the background information on the CfC Initiative including an outline of the demographic and epidemiological outcomes for children in the Murraylands Rural Region. Additionally, the introduction outlines some of the theoretical basis for the models of care and the therapeutic models of care that are common in all the programs provided. Subsequent sections provide the therapeutic models of care specific to the program provided by the organisation or service. The report also provides a conclusion for each program type; i.e. the program provided to parents and children, and the program provided to staff/workers in the Murraylands Rural Region, and the conclusion for the evaluation research project.

Background

There are known linkages between child maltreatment and levels of economic and social stress that are generally prevalent in areas of relative disadvantage (Access Economics Pty Limited 2008, Maggi, Irwin et al. 2010, AIHW 2012). Accordingly, Communities for Children

(CfC) was established in 2004 following a decision by the then Australian Government to establish the 'Stronger Families and Communities Strategy' (2004–08). Communities for Children was one of four streams of the Strategy, with the aim of addressing the risk factors for child abuse and neglect before they escalate, and to help parents of children at risk to provide a safe, happy and healthy life for their children and thus circumvent the deleterious health, education and welfare outcomes for children at risk.

Underpinned by the social determinants of health (Maggi, Irwin et al. 2010), the CfC strategy's key feature sought to engage parents and care givers in activities that enhanced their children's development and learning. The CfC program providers have developed activities such as home visiting, early learning and literacy programs, early development of social and communication skills, parenting and family support programs, and child nutrition programs (Allen 2011, AIHW 2012, Australia 2014). Communities for Children is a community based strategy aimed at improving an areas' childhood disadvantage factors through programs that target disadvantaged families living in these areas. An area of childhood disadvantage can be determined by the Australian Early Development Census (AEDC) levels of vulnerability scores for children in the area.

ac.care is the Facilitating Partner of CfC Murraylands and, as such, acts as a broker in engaging the community in the delivery of children's and parent's programs aimed at enhancing community outcomes (Muir, Katz et al. 2010). The CfC initiative aimed to improve the coordination of services for children 0-12 years and their families to minimise the impact of area-based disadvantage (Muir, Katz et al. 2010). Further, the initiative aimed to build community capacity to provide appropriate, targeted and enhanced service delivery and improve the community context for children (Muir, Katz et al. 2010). The whole community approach to improving child development incorporated the needs of the community (Muir, Katz et al. 2010). This report presents the findings from the evaluation of the ac.care Aspire Children's Development and Wellbeing program.

The parenting and staff development aspects of the ac.care Aspire Child Development and Wellbeing program is delivered at various sites and towns near Murray Bridge, South Australia. The ac.care Aspire Child Development and Wellbeing program provides an integrated service delivery approach supporting parents to; build their capability to meet their

child's developmental needs; provide essential early interventions programs that promote child development and wellbeing, and improve their relationships with their children. The program also aids parents in accessing other programs through individual support and links with referral agencies and the broader community service sector. This holistic approach to supporting families enhances child development through the access to services in a timely fashion. The ac.care Aspire Child Development and Wellbeing program delivers preventative interventions based on evidenced based theories and the targeted relationships frameworks. The program aids parents in dealing with behaviour issues and assists parents in preparing young children to integrate into playgroups, kindy and school.

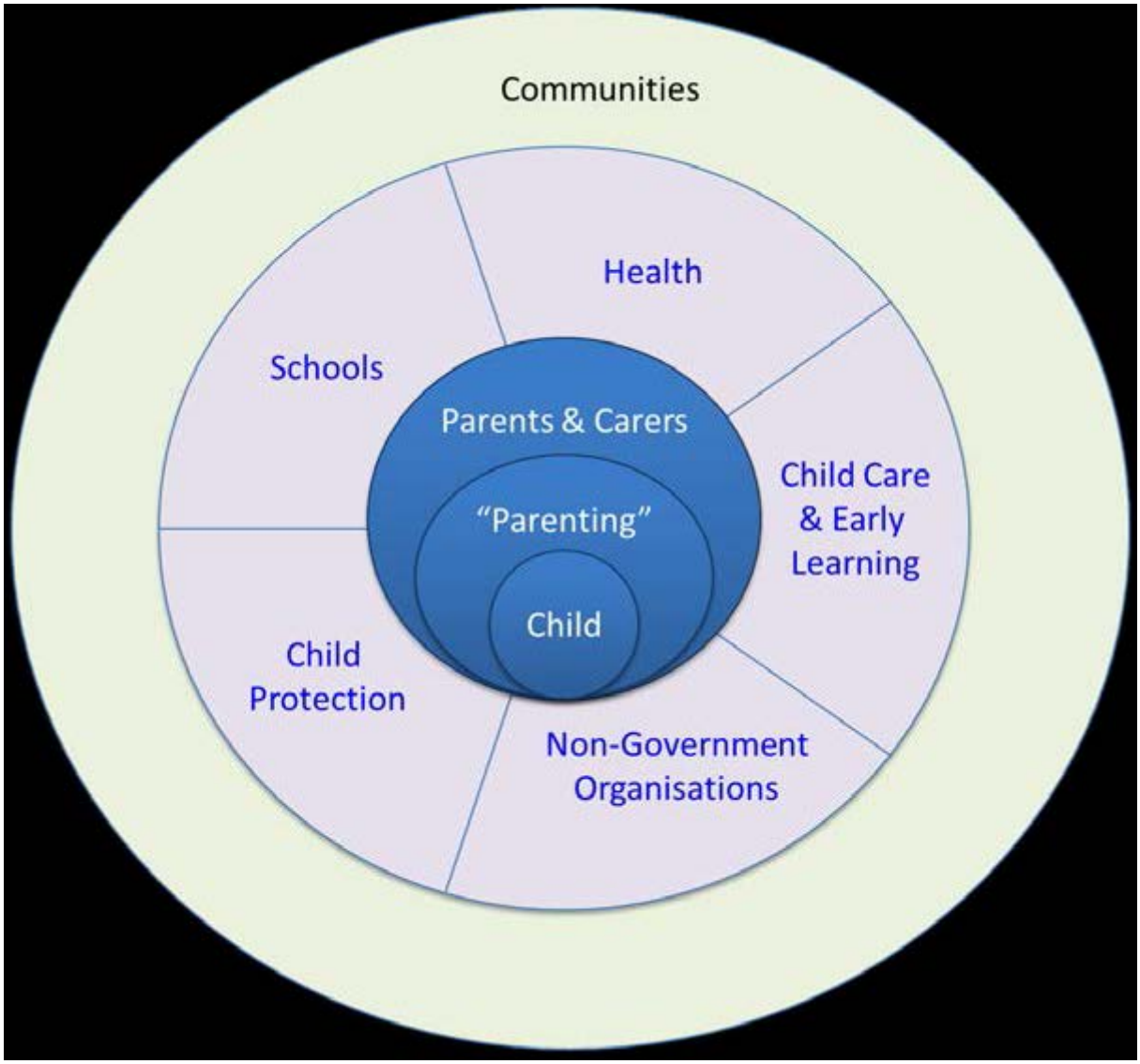
The Aspire Child Development and Wellbeing program has evolved over several years to meet the levels of vulnerability found in the area, the needs of the parents and children, and the needs of staff/workers who may work directly or indirectly with children. For example, mental health professionals may work addressing parental mental health, therefore, child developmental knowledge enhances parental and children's outcomes. The Aspire Child Development and Wellbeing program helps achieve this by aiding the mental health staff in acknowledging the needs of the children and child development through continuing education programs. The Aspire Child Development and Wellbeing program has developed over several years to use sympathetic and foundationally similar evidence-based programs that are integrated to deliver holistic community responsive programs.

Theoretical Basis for Program Models
Targeted relationship based programs

Early human development impacts on health, learning, and behaviour throughout life (Mustard 2010). Programs targeting parents of children at risk aim to decrease the impact of the negative characteristics of some of the Social Determinants of Health (SDH) (Solar and Irwin 2010) and address the children's potential level of complex vulnerabilities that accumulate to produce poorer adult health outcomes (Mackintosh, White et al. 2006, Noble-Carr 2007, DoCS 2009, Keys 2009, Dockery, Grath et al. 2010, Gibson and Johnstone 2010, Parry et al. 2013, Solar and Irwin 2010, Marcynyszyn, Maher et al. 2011, Nelson and Mann 2011, Kilmer, Cook et al. 2012, McCartney 2012, McCoy-Roth, Mackintosh et al. 2012, Zlotnick, Tam et al. 2012, Coren, Hossain et al. 2013, Embleton, Mwangi et al. 2013, Roos, Mota et al. 2013, Kuehn 2014). Of note, the use of parenting programs has been effective in decreasing emotional and behavioural problems in children (Wyatt Kaminski, Valle et al.

2008). This includes children with behavioural conduct disorder, oppositional behaviour, attention-deficit hyperactivity disorder, and anxiety disorders (Wyatt Kaminski, Valle et al. 2008, DoCS 2009). In addition, there is evidence that investing economically in early childhood programming for children in disadvantaged circumstances has sustained benefits for the community and from a human resources perspective (Belfield, Nores et al. 2006, Mustard 2006, Noble, Norman et al. 2006, DoCS 2009, Moffitt, Arseneault et al. 2010, Bartik 2011, Reynolds, Temple et al. 2011, Richter and Naicker 2013). Early Child Development (ECD) research has established that infants and children, who participate in well-conceived ECD programs tend to be more successful learners in kindergarten, primary, secondary and tertiary education, are more competent socially and emotionally, and show higher verbal and intellectual development during early childhood than children not enrolled in high quality programs (Mustard 2006, DoCS 2009, Dockery, Grath et al. 2010, Mustard 2010, Reynolds, Temple et al. 2011). Ensuring healthy child development, therefore, is an investment in a country's future workforce and capacity to thrive economically and as a society (Reynolds, Temple et al. 2011). Figure 1 below illustrates the interconnections between health, welfare, and the community.

Figure 1 A child centred approach for social support (Sawyer, Gialamas et al. 2014).



Supporting children and parents through community based programs is soundly theoretically based as figure 1 is based on the bio-ecological theory of development (Sawyer, Gialamas et al. 2014).

The Communities for Children program offered through ac.care Aspire Child Development and Wellbeing provides Early Childhood Development and Parenting programs, to target the most vulnerable and disadvantaged members in society, with the goal of reducing risk factors and improving family functioning and wellbeing. An evaluation of whether the programs efficacy is necessary to ensure funds have been well spent and to secure continued funding and expansion of such programs.

The impact of children's environment on their development

The health of children is determined within the context of the environments in which they are born, grow, live, play, and learn (Krieger 2001, Marmot and Wilkinson 2006, Brandt and Gardner 2008, Solar and Irwin 2010). A range of determinants have been identified that shape the health of children and families. These education, housing, employment, health access, income, gender and social processes, such as social support and social exclusion are coined the Social Determinants of Health (SDH) (Krieger 2001, Marmot and Wilkinson 2006, Brandt and Gardner 2008, Solar and Irwin 2010). As such the SDH are the aspects of people lives in which they are born, grow, live, work, and age (Maggi, Irwin et al. 2010). This definition incorporates a variety of factors that impact on children and influence their adult health status. The SDH represent a broad array of characteristics that are not biological or genetic but result from the social, physical, and community environments (Maggi, Irwin et al. 2010).

The social determinants of health (SDH) are recognised as measures of individual and structural characteristics that can be addressed to assist families and communities to move away from vulnerability (Wilkinson and Pickett 2005, Wilkinson and Pickett 2009, Maggi, Irwin et al. 2010, Solar and Irwin 2010, Shonkoff and Garner 2011, Sinclair 2014). The concepts that define the SDH enable research into the structural and intermediary influences on health outcomes. Significantly, these concepts provide a means of understanding differences in health outcomes for different population groups (Hetzel, Page et al. 2004, Wilkinson and Pickett 2005, Wilkinson and Pickett 2009, Solar and Irwin 2010, Shonkoff and Garner 2011, Sinclair 2014).

Additionally, the Social Determinants of Health (SDH) provides a framework for exploring health inequities against services that provide supported, wrap around, models of care and intervention, which deliver individual support across a broad range of determinants of health through links with community health, education and welfare services. The development of community based models of care that address health inequities have been shown to deliver significant improvements (25%) in children's development, behaviour, education, and health outcomes using community based relationship partnerships in the delivery of targeted parenting programs (Parry and Abbott 2016). As the programs provided by CfC promote the community based delivery ethos then using the SDH measurements could also highlight the impact of these programs on the community.

Migrant and refuge families, and parenting

Migrant and refugee families can have complex needs (Lewig, Arney et al. 2009). Refugee families have often been subjected to traumatic experiences before arriving in Australia (Lewig, Arney et al. 2009). Parents have endured human rights abuses, trauma and loss often associated with genocide, rape, war and torture (Lewig, Arney et al. 2009, Renzaho and Vignjevic 2011). These life circumstances can leave parents emotionally and psychologically impacted by trauma which can impede functioning at times of parental stress, such as differing acculturation rates between parents and children (Renzaho and Vignjevic 2011). As acculturation occurs faster in children than parents resulting in different expectations of family, gender roles, domestic violence, and parenting styles (Lewig, Arney et al. 2009, Renzaho and Vignjevic 2011).

Additionally, parenting practices and styles may be vastly different than those viewed as acceptable in Australia (Lewig, Arney et al. 2009, Renzaho and Vignjevic 2011). For some cultural groups the use of punitive or corporal punishment styles are common place in parenting (Lewig, Arney et al. 2009, Renzaho and Vignjevic 2011). This authoritarian style is often at odds with Australian parenting styles and child protection expectations (Lewig, Arney et al. 2009, Renzaho and Vignjevic 2011). For example, some refugee and migrant groups use older children to care for younger children or leave children unattended while the parents are at work. This practice can, in some circumstances, constitute abuse and neglect in the Australian child protection context (Lewig, Arney et al. 2009, Renzaho and Vignjevic 2011). There is an over representation of refugee and migrant families in the child protection system (Lewig, Arney et al. 2009, Renzaho and Vignjevic 2011). Improving parental capacity and competencies is paramount given the increasing numbers of migrant and refugee families in the chid protection system (Lewig, Arney et al. 2009, Renzaho and Vignjevic 2011). Promoting culturally competent parenting practices aim to decrease child protection notifications, poorer child health outcomes, and numbers of refugee and migrant children in out of home care (Lewig, Arney et al. 2009, Renzaho and Vignjevic 2011).

The Aspire Child Development and Wellbeing program is responsive and intentional by design and focuses on meeting the needs of the children, families and community. The program aims to improve family functioning, and child wellbeing by providing early intervention and prevention services to families to assist and enhance family functioning and support parents to care for their children in accordance with the aims of the DSS, CFC,

website. Additionally, International and national researchers found that programs that directly respond to the needs of the community and parents are more effective than standalone, narrow focused, or limited intervention programs (Bromfield, Sutherland, and Parker 2012). Bromfield, Sutherland, and Parker (2012) extensive research on intervention practices found that while “most parents are able to achieve their parental goals with assistance and guidance from a network of family, friends and community supports…Vulnerable families are those who have a limited network of family and community support and find it difficult to access additional services. Particularly vulnerable families are those that have been impacted by social disadvantage, and have family members who may have physical or mental health problems, disability, substance abuse or have experienced family violence” (Bromfield, Sutherland, and Parker, 2012, p 38).

Therefore the most vulnerable and at risk children need parenting intervention programs that are based on reflective and complementary programs that reflect the local need. The programs delivered by the Aspire staff remain true to the evaluation and evidence-based premise of the foundational programs and respond to the community needs. This is only possible as the staff are highly trained in the foundational programs, keep up-to-date in their knowledge and applications of the programs, and have many years’ experience in program delivery. The Aspire Child Development and Wellbeing program has been developed since 2009 towards its current iteration from 2014. It has taken several years to deliver evidence-based programs in a manner that is in tune with the local professionals, families, and the community. The program addresses the needs of all community members including Refugee, Aboriginal, and Culturally and Linguistically Diverse (CALD) members. Improving child developmental outcomes involves parents (Hannar and Rodger 2002, Bromfield, Sutherland, and Parker, 2012,). The importance of interventions that directly change parenting behaviour are paramount in addressing child vulnerabilities (Bromfield, Sutherland, and Parker, 2012). The Aspire Child Development and Wellbeing program directly addresses parenting along with directly addressing child development through appropriate language development, play and learning activities. The tertiary qualified program staff provide an individual assessment for each child and collaboratively set goals with parents that promote child development and wellbeing. Complex families addressing multiple disadvantage, such as cultural, economic, and geographic, are only successfully assisted using multiple pedagogical and theoretical interventions and educational processes (Wood, 2007). Reified developmental theories and

child centred approaches to ECD learning and play have provided new evidenced-based informed practices that inform interdisciplinary program delivery and community integration (Wood 2007). Therefore, the interprofessional and multi-professional services provided by the Aspire Child Development and Wellbeing program directly addresses the recent theoretical advances that challenge the use of singular interventions and developmental theories.

Communities for Children Programs

Our clients: ac.care, Murraylands, Aspire Child Development and Wellbeing

The Communities for Children Facilitating Partner programs are funded by the Australian Government Department of Social Services and aimed at delivering strong outcomes for Australian families with a focus on early intervention and prevention to provide programs for children aged 0-12 years and their families (AIHW 2012, Stewart 2014). Research shows that children living in poverty are exposed to higher levels of stress and this interferes with their ability to learning and meet developmental milestones (Margolin and Gordis 2004, Suor, Sturge-Apple et al. 2015). Furthermore, the differences in cognitive ability are evident at aged four (Margolin and Gordis 2004, Suor, Sturge-Apple et al. 2015), therefore addressing child development and wellbeing through early interventions is imperative in preventing long term cogntive deficits that impair school performance and outcomes. The Murraylands Rural Region of South Australia has been recognised as an area where children experience high rates of developmental vulnerability (Australian Early Development Census 2015). There are five measures that outline domains of vulnerability for Australian children in the Australian Early Development Census (AEDC). The five domains are: physical health and wellbeing; social competency; emotional maturity; language and cognitive skills (school based), and, communication skills and general knowledge (Australian Early Development Census 2015). In Australia 6.8% of all children aged 0-12 years are assessed as being developmentally vulnerable in one or more domains (Australian Early Development Census 2015). In the Murraylands Rural Region of South Australia, in 2009, 43.5% of children are assessed as developmentally vulnerable in one or more domains and a further 34.8% assessed as developmentally vulnerable on two or more domains (Australian Early Development Census 2015). Of significance, is the decrease in the percentage of children assessed as vulnerable during the time the Communities for Children (CfC) programs have been implemented. In

2015, for example, 16.7% of children in the Murraylands Rural Region of South Australia were assessed as developmentally vulnerable on one or more domains. This has decreased significantly by -26.8% (Australian Early Development Census 2015). Furthermore, the percentage of children assessed as developmentally vulnerable on two or more domains in 2009 was 34.87%, and in 2015 this had decreased significantly to 11.1% a change of -23.7% (Australian Early Development Census 2015). While the Murraylands Rural Region of South Australia is still behind the Australian average of 6.8% (Australian Early Development Census 2015) initiatives, such as the CfC programs, aim to address children's vulnerability. The graph (5) below from the AEDC website indicates the improving results for children in Murraylands Rural Region of South Australia. The figure below outlines the emerging trends from the AECD website for the Murraylands region as of June 2016.

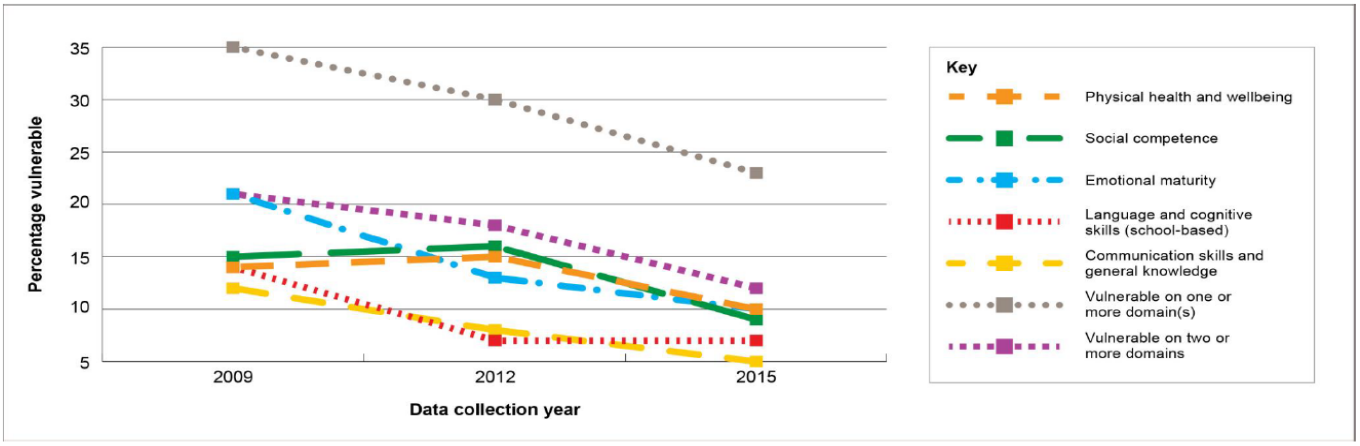
5: Emerging trends in child development in this community

As data is available from three points in time, we can start to consider emerging trends. Figure 2 shows change in the percentages of developmentally vulnerable children in this community from 2009 to 2015.

The following pages show emerging trends for each AEDC domain in more detail.

The graphed data in Figure 2 is repeated in Table 7, below.

Figure 2 – Emerging trends in developmental vulnerability for this community, showing change in percentage (2009 to 2015).



The figure above shows an improvement in the AECD outcomes across all developmental domains. The levels of vulnerability across the AECD domains are decreasing in this area. The period of these improvements coincides with the development and implementation of the communities for children programs in the region, including the delivery of the Aspire Children's Development and Wellbeing program. This area has a high number of refugees and migrants which also impacts on the AEDC scores. The improvements are of note especially considering the economic decline in this area over the same period.

Significance of the program and this research

Programs targeting parents of children who are at risk aim to decrease the impact of the SDH and address the children's potential level of complex vulnerabilities that accumulate to produce poorer adult health outcomes (Keys 2009, Gibson and Johnstone 2010, Muir, Katz et al. 2010, Solar and Irwin 2010, Department for Education 2011, Nelson and Mann 2011, Kilmer, Cook et al. 2012, McCartney 2012, McCoy-Roth, Mackintosh et al. 2012). Importantly, research shows that the use of parenting programs has effectively decreased emotional and behavioural problems in children (Wyatt Kaminski, Valle et al. 2008, Sandler, Schoenfelder et al. 2011). This includes children with behavioural conduct disorder, oppositional behaviour, attention-deficit hyperactivity disorder, and anxiety disorders (Wyatt Kaminski, Valle et al. 2008, Sandler, Schoenfelder et al. 2011). In addition, there is evidence that investing economically in early childhood programming for children in disadvantaged circumstances has sustained benefits for the community and from a human resources perspective (Access Economics Pty Limited 2008, Wyatt Kaminski, Valle et al. 2008, Sandler, Schoenfelder et al. 2011).

The Communities for Children Murraylands program facilitated by ac.care provides early intervention and prevention programs based on community need through Community Consultation targets the most vulnerable and disadvantaged members in society, with the goal of reducing risk factors and improving family functioning and wellbeing. This report details research that aimed to explore the relationship between CfC programs delivered in the Murraylands Rural Region of South Australia and the social determinants of health for the children and families who have used the service. Whilst such programs appear sound from a theoretical perspective, unless there is evidence of the outcomes of the program, the work cannot be validated for continued funding or for wider application. This type of analysis and research provides the bridge between policy objectives and the practice applications of policy. This research provided the next keystone step in examining the broader impact of individually tailored programs. The research presented here provides validation of the Aspire Child Development and Wellbeing program and its evidence-based practice, along with the supporting documentation for its potential wider application. Of note is the limitation that despite the use of validated and evidence-based programs the Aspire Child Development and

Wellbeing program has been developed to meet the specific needs of this vulnerable rural community.

AIM of the evaluation research

To explore the relationship between CfC programs delivered in Murraylands Rural Region of South Australia between 2015 to 2017 and and changes in parenting/carer behaviours in the children and families who have used the service. Along with the changes in children as measured by the validated tools used in the Aspire Child Development and Wellbeing program.

OBJECTIVES of the evaluation research

1. To identify the vulnerabilities impacting on the children and families using the service.
2. To explore the relationship between participating in the Aspire Child Development and Wellbeing program and changes in parents and their children.
3. To develop a set of recommendations that would enhance the programs' capacity to improve the intended outcomes for the staff/workers, parents and children.

These objectives represent the first step in determining the extent to which the CfC programs impact on the children broader social outcomes. The provision of a comprehensive program logic (Appendix A) and the manual for the program ensures the program is available for wider dissemination, application and use in other settings (Appendix B).

Approach to evaluation research

The mixed methods methodology and data management processes informed this research project. The qualitative methods were used predominately in this evaluation research project which was undertaken in two stages. The use of multiple stages and various sources of information improves the robustness of the research process.

The first stage involved:

1. The literature review explores the theoretical and evidence bases for the programs provided.

Stage two included:

1. A combination of interviews and focus groups with professionals, providers, staff, and parents.
2. Thematic analysis to provide an in-depth understanding of the impact of these programs on several health, welfare and social outcomes.
3. A review of the Goal Achievement measures for children 0-5 years.

The leading research methodology used in this evaluation is qualitative. However, some quantitative data collected by ac.care Murraylands staff as part of their program performance analysis and quality improvement of their programs was fundamentally in the analysis in the first instance as it informed the qualitative data collection. Using this mixed–method approach (Patton 2002, Parry and Willis 2013) ensures that this evaluation will be more robust. The inclusion of qualitative data is important as it bridges the current gap in evidence provided by quantitative data.

Qualitative Methodology

The qualitative component of the study was undertaken within a broad framework of critical social theory. This enabled the researchers to consider multiple positions, such as gender, race and poverty as they affect the SDH outcomes of children and families. Importantly, it situates the research as inquiry to inform change.

The subjective nature of qualitative enquiry has several relatively stable criticisms. The qualitative researcher selectively collects and analyses data that is not representative (Bogdan and Taylor 1975). Generalisations are consequently not appropriate. Qualitative enquiry is only appropriate as a research design where an in-depth understanding is required of a group of people who have been purposefully selected (Patton 1990). This is imperative here as this research project sought to explore the changes made by participation in the Aspire Child Development and Wellbeing program facilitated by ac.care Murraylands. Here the data selected specifically explores the outcomes of the Murraylands Rural Region of South Australia programs on the parents and children.

While quantitative data provides a broad understanding of some influences on family circumstance, such as attendance, qualitative data, stories and narratives provide a personal perspective on life and family circumstances. Both sources of information are useful and

highlight the influences on how children and families cope with adverse life circumstances and make decisions (Bogdan and Taylor 1975, Parry and Willis 2013). The qualitative data provided in the interviews represent how the participants see themselves, their young children and their family within a social structure and their capacity for empowerment and self-determination (Parry 2012). This in turn informs a parent's ability to deal with stress and seek help when needed.

Social and power implications of narrative analysis

Researchers have found the use of narrative analysis important in discovering the underlying socio-political impacts on population groups (Kohler Riessman 1993; Lieblich et al. 1998; Czarniawska 2004; Daiute & Lightfoot 2004). As Kohler Riessman (1993) notes:

> *The use of narrative analysis is important as all narratives are socially constructed and laced with social discourse and power relations (Kohler Riessman 1993 p. 65).*

As such qualitative research using narratives provides a useful insight into the social and power relations that influence the participant's decisions. This allows for the inclusion of the family story within the SDH and demographic data that explains the impact of the Aspire Child Development and Wellbeing program on the care and development of young children and the intra-family relationships. Thus, the inclusion of narratives allows parents to express how the program impacts on their lives and their families. Qualitative research and narrative analysis is the broad term used to describe a research act that aims to obtain from the participants detailed accounts of their lived experience through their stories. In practice, many such projects have focused their attentions on vulnerable or marginalised groups, thus containing an emancipatory emphasis, but the method can be used with any group of people (Davies 2007; Duffy 2008, Parry and Willis 2013).

Data Management and Analysis

All copies of transcripts and any other pertinent qualitative and quantitative data sets are kept in a locked cabinet at Flinders University for seven years and then destroyed to comply with A.F.I. legislation.

Qualitative data management and analysis were completed in two separate but related steps in a procedure recommended by Patton (Patton 1990). The recordings were transcribed verbatim and pseudonyms assigned as the initial step to managing and analysing the data.

Qualitative data was analysed manually. Transcripts were disseminated into their component parts regarding the original question categories. Respondent selections were separated and colour coded in a procedure outlined by Cavana et al (2001). Care was taken at this point as all data taken at the first instance as relevant and useful. There was a need to carefully identify statements that were made by the participants on issues that were not core to the focus of study, yet remained important, and those statements that were more clearly relevant.

The data was then inductively analysed. Patton (1980, p.306) describes inductive analysis as patterns, themes and categories of analysis come from the data; they emerge out of the data rather than being imposed on them prior to data collection and analysis. Themes that emerged from the data were analysed in terms of the constant comparative method as described by Glaser and Strauss (1967). This method requires that themes be examined as they emerge directly from the raw data and compared to each other to ensure they are not different aspects of a previously designated theme (Glaser and Strauss 1967, Cavana, Delahaye et al. 2001).

Additionally, the thematic data was deductively analysed using an iterative process to connect the Aspire Child Development and Wellbeing program results to the theoretical basis and themes arising from the interviews and focus groups (Grant & Booth 2009). Critiquing the qualitative results against the literature review improves the robustness and validity of the research findings and here ensures the program under evaluation is soundly theoretically based.

Marshall and Rossman (1999) note that an alternate understanding will always exist and the job of the researcher is to argue and reason why the explanation associated with the data is a better explanation than the alternate understanding. Patton (1990) warns that researchers are always at risk of being accused of imposing an understanding that reflects the researcher's world better than the world being studied. The search for alternate understandings was considered and one method that could be used was to counter this accusation.

Selection of participants

The use of multiple sources of information and informants enhances the validity and robustness of the findings (Parry and Willis 2013). Therefore, selecting the participants in the qualitative phase consisted of an evaluation of their use of the programs, as staff/worker (continuing education programs), collaborative referral recipients, or parents which then resulted in their inclusion due to their key informant status. This process constituted a critical snowballing approach to participant recruitment. Furthermore, the managers (ac.care Murraylands) and staff (OT and SP) employed in the programs provided important theoretical knowledge and background on program development and implementation.

Exclusion and inclusion criteria

The use of multiple sources of information and informants enhances the validity and robustness of the research results. The family participants selected for interview were recruited using a critical snowballing method (Hansen 2006, Parry 2012). Critical snowballing uses key professionals to provide information on possible suitable participants for research (Hansen 2006, Parry 2012). The method of sampling was also important to enhance rigour and whilst random sampling is preferred it is not appropriate for qualitative studies (Hansen 2006, Parry 2012). To maintain confidentiality and enhance the inclusiveness of the study the participants were selected by the staff of the Aspire Child Development and Wellbeing program. This constitutes a form of, critical appraisal, chain, or snowballing sampling, where by key informants, in this case the staff, suggest families to be involved in the research (Hansen 2006, Parry 2012). The participants then self-select to be involved in the research. The extensive list of potential participants was provided by the staff. This ensured that the researcher had no prior knowledge of the participants or their family situations, and additionally, ensured the staff did not know which participants had agreed to participate, providing anonymity and confidentially. Those parents using the Aspire Child Development and Wellbeing program were then identified by the staff and then approached via a letter/phone call for recruitment into the study. All participants volunteered freely to participate in the research, and had participated in all the Aspire Child Development and Wellbeing sessions. Additionally, all participants spoke English well enough to understand and answer the questions.

Qualitative research and narrative inquiry uses the narratives that emerge from interviews and examines the material within the context of how the data and participants are situated in the social world. Meanings are derived through the deconstruction and reconstruction of the narratives defining structural elements (Duffy 2008).

Interview questions

Questions asked were open ended and simple in structure to elicit the participant's in-depth responses and to obtain responses unconnected with the researcher's experience or bias. The interview and focus groups covered several characteristics highlighted by the literature and past evaluations:

- The type of program;
- The usefulness of the program;
- The impact of the program[s] on other aspects of the participants lives (e.g. the SDH)*;*
- Implications for changes;
- Impact on health (mental and physical);

The above considerations were used as a guide for the design of the questions. The interviews were of 20 minutes to 120 minutes in length and the focus groups were between 60 minutes and 120 minutes in length. The interviews were either face-to-face or via the phone depending on the participant's preference. The initial data collection took place in the Murraylands region of rural South Australia. However, the data collection in the workshops provided to professional were state based as some professionals had relocated to other areas.

Community engagement strategies

A research reference group was established from the various agencies delivering the CfC programs. This enabled the collaborative involvement of the service providers in the research ensuring the inclusion of key stakeholders in a democratic process. Furthermore, assuring the final recommendations are usable. The research reference group verified the variables definitions for stage one and assist in the development of the qualitative questions for stage two interviews and focus groups.

The researchers analysed the interview responses from staff, community service providers (staff/workers in continuing development programs), and parents. The analysis was presented to the reference group for consideration and comment. The results of the first two phases informed the development of a set of recommendations for future service delivery of interventions of children at risk and their families. As well as provide a framework for future service evaluations and data collection. These could be used to ensure the effectiveness and viability of the CfC programs using an evidenced based perspective.

This report is divided into five sections with each section reporting on one aspect of the research evaluation. The first section (above) provides an overview and background on the CfC program nationally and the AEDC demographics of the area where the ac.care program is delivered. The second section reports on the program economic rational and the facilitator qualifications. The third section provides the literature review of the program target population, the theoretical models informing professional practice, and the preventative interventions used. The fourth section reports on an evaluation and results of the Aspire Child Development and Wellbeing program delivered by ac.care Murraylands. The fifth section provides a discussion linking the results and the literature providing the evidence for the program's success and the conclusions for the use of the program.

Section two:

The ac.care, Murraylands, Aspire Child Development and Wellbeing Program

Introduction

This section reports on research with the ac.care Aspire Child Development and Wellbeing program funded by Communities for Children (CfC). The research explored the relationship between Communities for Children (CfC) programs delivered in Murraylands Rural Region of South Australia and some of the Social Determinants of Health (SDH) for the children and families who have used the service (Parry et al. 2013, Solar and Irwin 2010). Communities for Children (CfC) provide prevention and early intervention approaches to improve outcomes for children (0-12 years old) and families who are at risk. These programs are sound from a theoretical perspective. The Aspire Child Development and Wellbeing program incorporates fundamental theoretical aspects of improved parental care, such as Targeted Relationship Building, Attachment Theory, The Circle of Security Parenting, Hanen language development program, along with Trauma Informed Principles for interventions while addressing the broader constructs of the Social Determinants of Health (SDH), such as education, access to services and aspects of service delivery (Parry et al 2016). Further, the Social Determinants

of Health (SDH) frameworks provide a means of exploring the impact of social phenomena, for example limited: income, health access, community capacity, and family support, on individual aspects, such as health and wellbeing outcomes. The type of analysis and research undertaken for this evaluation provides the bridge between policy objectives and the practice applications of policy on SDH outcomes (Stewart 2014).

The current ac.care Aspire Child Development and Wellbeing program suite commenced in 2014 to provide activities free of charge, that include food, parent/child interaction modelling, nutritional advice, behaviour management techniques, and equipment use e.g. play equipment, books etc. This encourages the participation of families experiencing disadvantage and social isolation in learning activities that promote positive parenting, child development and learning. The extent, to which the Aspire Child Development and Wellbeing program meets the aims of increasing parents or carers capabilities and strategies to meet their child's developmental needs, and the subsequent, child developmental improvements, reducing social isolation, and providing positive community outcomes, is evaluated by this research project through analysis of the goal achievement tools and outcomes along with the focus group and interview data. The exact program outline is discussed later in this chapter.

The evolution of the Aspire Child Development and Wellbeing Program to meet community needs

The ac.care Aspire Child Development and Wellbeing program has evolved and developed to directly address community needs. The initial program commenced prior to 2010 with the original focus on preparing young children for kindy and school. The program was assessed in 2010/2011 by the social worker delivering the program and it was determined that for the program to be effective and meet its aims the program needed to be delivered by Health Professionals. An Occupational Therapist and Speech Pathologist were employed to deliver the aims and outcomes of the program given their tertiary education levels along with knowledge on child development. Additionally, the program expanded to provide child developmental educational sessions and knowledge to local health professionals, human services professional and educational staff, such as kindy and primary school teachers. The program now has two major components; the parent's skills, and the regional staff skills development. These two programs are briefly outlined below:

Enhancing parenting skills

The ac.care Aspire Child Development and Wellbeing program provides intensive and comprehensive support for parents (mainly mothers) who recognise the need to address behavioural problems in their young children. Parents are also referred to the program by other education and health professionals in the Murraylands region. Behavioural problems can include: toilet training, eating and food refusal, sleep and sleeping routines or not meeting social developmental milestones, such as sharing, locus of control, ability to concentrate on an age appropriate tasks.

The targeted interventions aim to provide parents with strategies to enhance a child development so the child has the best possible start to schooling. The Allied Health Professionals providing the program, effectively engage with the parents and caregivers, to devise realistic, achievable, measurable and specific goals for the child to attain with the support of the parents. This process also empowers the parenting skills through the practical application and use of 'strengths based interventions'.

Regional health, welfare and educational professional's skills building program (aims)

The ac.care, Murraylands, Aspire Child Development and Wellbeing program, provides education and training in intensive child development and comprehensive support for children experiencing; behavioural issues, social developmental delays, exposure to trauma, possible autism, and communication issues for local professionals. The aims of this aspect of the Aspire program includes:

- Being responsive to the needs of other health and human services professionals in the area,
- Assisting other service staff to aid parents in receiving quality services and evidence based best practice services,
- Providing developmental education (this may have been missing from the professional's original qualifications
    - E.g. social workers do not have child developmental professional qualifications as different from Child Aware Approaches information/topic in their undergraduate degree,
- Providing trauma informed practices to other services and professionals,
- Providing targeted and contextually relevant information and referral pathways as the knowledge of the Aspire staff is Murraylands referral specific

This enables the local professionals attending the education and training program to recognise children who may require referrals to the appropriate clinic or health intervention. The variety of professionals attending the education and training programs includes:

- School Learning Support staff
- Teachers (kindergarten and primary school)
- Nurse/Midwives
- CaFHS
- Aboriginal Crèche staff

The use of highly trained Aspire professionals to deliver educational and training to other local professions enhances the local skill base, referral pathways and networking opportunities in the Murraylands area. The educational workshops help professionals to developed processes and procedures for the recognition of potential problem behaviours that may interfere with kindy and school readiness. Early intervention is imperative in addressing aspects of infant and child development that may impact on learning and social development as the child grows.

Economic rationale / Social return on investment

The ac.care Aspire Child Development and Wellbeing program provides intensive and comprehensive support for parents (mainly mothers) who recognise, or are referred to the program, to learn more about their infants and children's early development, are feeling/behaving disengaged with their children and/or have parenting issues, such as child behaviour issues, for example, issues with toilet training. The combination of the supportive care of the mothers or carers, an intensive intervention strategy, and an activity program has been found in research to be vitally important in providing successful interventions to mitigate the profound development issues for children who fail to meet developmental milestones (Taylor, Moore et al. 2009). Failure to meet developmental milestones can be a form of abuse or neglect (Taylor, Moore et al. 2009). In Australia, Access Economics et al (2009) estimate that in 2007, between 177,000 to 666,000 children under the age of 18 were abused or neglect and this costs between $10. 7 billion and $30.1 billion to the community (Taylor, Moore et al. 2009). The ongoing costs of child abuse and neglect for Australia could be as high as $38.7 billion. For every $1 spent in Australia on early intervention programs for preventing child abuse and neglect there is a $15 saving in adult health costs (Taylor, Moore et al. 2009, Allen 2011, Deloitte Access Economics and PANDA 2012). The use of early

detection, prevention and intervention programs for parents, and carers in caring for children has the potential to save public expenditure. The ac.care Aspire Child Development and Wellbeing program provides preventative and therapeutic interventions delivered by an Occupational Therapist, and a Speech Pathologist. To provide these services, one-on-one, to parents would not be cost effective. For example, if 10 parents attend a two-hour program per week, this equates to 20 hours per week of individual sessions to deal with the same child behavioural and developmental issues. The targeted playgroup format enables the delivery of this information and intervention in a method that is cost effective. Additionally, to provide one-to-one therapeutic interventions for the numbers of clients currently using the service would require 6 FTE staff instead of the current 1 FTE (the staff are part-time). The use of group work here is cost effective and appropriate as parents who have previously participated in the Aspire Child Development and Wellbeing program can return and often encourage other parents to participate. The targeted playgroups are delivered under the guidance of the Occupational Therapist and Speech Pathologist, to provide support and mentoring for families.

The ac.care Aspire Child Development and Wellbeing program evaluation used a concurrent mixed/multiple methods research project design to explore the use of directed preventative interventions, such as Targeted Relationship Building, Attachment Theory, Circle of Security Theory, and Trauma Informed Interventions, along with support and relationship based programs that aim to improve parent/carer relationships and practise within the family. Stage one involved the analyses of the literature. This stage provides an understanding of the theoretical foundations of the Aspire Child Development and Wellbeing program. Stage two consisted of the collection of data including: the number of attendees is a quantitative data source, (this data is already collected by Communities for Children program), and the outcomes of the Goal Achievement Tool. The quantitative data analysed was restricted to the descriptive statistics methodology and an analysis of the Goal Achievement Tool. The analysis of the quantitative data performed concomitantly with the qualitative data collection and analysis; interviews and focus groups. Qualitative data included interviews/focus groups with providers (managers and staff), community human, health, and education staff/workers, and interviews/focus groups with parents. Data were analysed thematically to provide in-depth understandings of the impact of these programs on the families. These two stages together will provide a broader and deeper understanding of whether the Communities for

Children (CfC) program improved health, education, emotional and social outcomes for children and families. This is consistent with the focus of the AEDC measurements and outcomes.

Facilitator Qualifications

Lead Clinicians: The current lead clinicians have Bachelor/Degree or recognised qualifications in Occupational Therapist and Speech Pathologist, specialising in childhood physical, cognitive, and social development, along with postgraduate qualifications in:

- Child Centred Professional Practice,
- Physical, cognitive, social and language development, and,
- Trauma Informed Principles of Intervention.

Additional training in the following areas has been completed:

- Hanen – it takes two to talk (you [parent] make a difference)
- Attachment Theory, and
- Circle of Security,
- Bringing Up Great Kids

The ac.care Aspire Child Development and Wellbeing program also provides family support work and has well established and maintained referral pathways and community links. The play and activities are provided by the Aspire Child Development and Wellbeing program improve child development. Play is important for a child's health, growth and development. The use of play is also an important aim of the Aspire Child Development and Wellbeing program as it enhances the parent's understandings of the importance of play and models how to play with children. Regular activity and play has many benefits for children. These include:

- Enhancing listening skills.
- Building strong hearts, muscles and bones.
- Fostering social interaction skills.
- Developing movement and co-ordination.
- Improving problem solving skills.
- Encouraging self-esteem.
- Developing emotional skills.
- Expanding communication skills.
- Developing self-regulation and impulse control.

The activities highlighted above involve the children and parents participating in safe and positive skills development that result in significant behaviour changes in the targeted families and children. The Aspire Child Development and Wellbeing program staff model support and encourage a safe environment where children can develop and learn. Additionally, the use of the theories, models of care, programs used, and equipment involved in the activities provided has necessitated the training of staff in a variety of programs and methods of delivery. For example, the Aspire Child Development and Wellbeing program staff receive regular training and continuing professional development in the Hanen program. The Hanen program provides parental education that promotes the child's development through early language interventions, skills, and social interactions development for children identified with potential language, social and communication difficulties (Hanen Centre 2016).

Section three:

Literature Review

Introduction

Initially, this innovative, preventive, intervention program commenced several years ago and actively sought the feedback of the local community to enhance the program to meet the communities and parent's needs. The program broadly consists of two main strategies or aims. The first, is to enhance the skills of parents and caregivers to address children with behavioural, language, communication and socialisation problems, and the second, is to upskill the other professionals working with children directly or indirectly in the local area, thus, creating a broad child centred approach to community engagement with local children. The program meets the needs of children who are aged 0-5 years, who are marginalised, vulnerable, and disadvantaged. As an activity based program it delivers evidence-based theoretical content and behaviour change through activities, such as reading, play both indoor and outdoor, and through active engagement that involves parents/carers connecting to their

children. This ensures that those with limited literacy skills, or other marginalised or disadvantaged groups, such as CALD and ATSI peoples can participate easily, without stigma or exclusion. This guarantees that the parents and community diversity and unique perspectives are included in the activities, and supportive of the development of the infants and young children. The parents attending are often isolated for example, migrant families, families involved in rural work and settings, or isolation through relocation for work far from supportive family members. The families are disconnected from family supports that are imperative at the time of an infant's birth, development and growth. Thus, the Aspire Child Development and Wellbeing program supports parents and carers in their aspirations to be effective and responsible parents/adults caring for children. The use of extended family, and family substitute/support programs, are paramount in improving children's health and wellbeing at a time of developmental vulnerability for the infant and child. The Aspire Child Development and Wellbeing program provides an innovative opportunity for disadvantaged, isolated, and stressed parents and carers, to change their parenting style to encompass evidence-based understandings of child development that directly addresses children's developmental needs. Furthermore, the program encourages the active participation of the parents in all activities and provides and early identification or basic assessment process (Goal Achievement Tool), and the use of extensive clinical knowledge to advise parents of the broader referral system and opportunities for children in need of extra support.

The Aspire Child Development and Wellbeing program has been instrumental in aiding parents in linking to other support services in a timely manner. For example, both therapists use their clinical knowledge and expertise to identify young children with difficulties in social communication, social interaction, and restricted or repetitive behaviours, and interests, that can be associated with possible autism. Any of these behaviours identified or other deficit disorder issues that may need referrals are brought to the awareness of the parents, and the parents are advised of organisations and support services that may provide help. This has aided the families' in obtained timely and appropriate interventions that have supported the development of their children. Early intervention in potential deficit disorders, behavioural, language, and social issues, ultimately assists children by helping in addressing issues to facilitate the integration of the children into mainstream kindergarten and school.

Theoretical Basis for the Program Model

Literature review

Targeted playgroup programs

The Aspire Child Development and Wellbeing preventative interventions provides targeted playgroups. Targeted playgroups are effective in mitigating the influences of poverty, isolation, young maternal age and parental mental health issues on infant and child development (Lakhani and Macfarlane 2015, Pourliakas, Sartore et al. 2016). Targeted playgroups for children birth to five years strengthen parent/child relationship through an understanding of children's appropriate behavioural, cognitive and social development, and can empower parents to effectively intervene with young children with expressive and receptive language disorders (Hanen Centre 2016). Participation by parents in these types of playgroups promotes protective factors for children experiencing vulnerable circumstances and developmental delays (Lakhani and Macfarlane 2015, Pourliakas, Sartore et al. 2016). For example, young parents, parental mental illness, parents with drug and alcohol issues or isolated parents (Lakhani and Macfarlane 2015, Pourliakas, Sartore et al. 2016).

Targeted playgroups are structured playgroups that provide evidence-based, targeted knowledge and services to enhance and promote infant/child development, health and well-being (Lakhani and Macfarlane 2015, Pourliakas, Sartore et al. 2016). These preventative intervention types of playgroups improve child socialisation consistent with increasing child well-being and health, while reducing the risk factors for children by keeping the children visible and connected to the community (Arney and Scott 2013, Parry, Grant et al. 2015). Further, targeted playgroups enhance parental well-being by improving parental connections to community, and reducing social isolation (Lukie, Skwarchuk et al. 2014). Additionally, the preventative interventions provided by targeted playgroups mentioned above improve numeracy and literacy in the child, promote school readiness, and enhance academic attainment (Lukie, Skwarchuk et al. 2014, Gregory, Harman-Smith et al. 2016). These types of activities, interventions, and services are also consistent with policy approaches and the key strategic outcomes of the Communities for Children Intervention.

Attachment theory

Attachment theory was developed in the 1970s by John Bowlby to explain the carer/child connection in terms of biological and psychological functioning (van IJzendoorn 1995). The theory describes the sensitivity and responsiveness of the parent or caregiver to meet the child's developmental needs as early attachment impacts on lifelong functioning (van IJzendoorn 1995, Van IJzendoorn, Schuengel et al. 1999, Centre for Parenting & Research 2006). Additionally, the measures used in the attachment assessments illustrate dysfunctional parent or caregiver responses to infants and children (van IJzendoorn 1995, Centre for Parenting & Research 2006). Responses from prolonged separations, either physically or psychologically impact on the child and their subsequent adult functioning and behaviour (van IJzendoorn 1995, Van IJzendoorn, Schuengel et al. 1999, Centre for Parenting & Research 2006). Longitudinal international research supports the use of attachment theory to predict infant, child and adult outcomes for appropriate parental responses to children's needs and for the development of adults' significant interpersonal relationships (van IJzendoorn 1995, Van IJzendoorn, Schuengel et al. 1999, Centre for Parenting & Research 2006). Further, attachment theory research explains the cognitive organisation and representations of interpersonal relationships and parenting behaviors (van IJzendoorn 1995, Centre for Parenting & Research 2006). The predicative capacity of the attachment theory measurements provides self-report and professional assessment items that consistently calculate levels of attachment and identify intervention pathways for program implementation (van IJzendoorn 1995, Van IJzendoorn, Schuengel et al. 1999, Centre for Parenting & Research 2006). Successful interruption of, reactive-attachment disorder, insecure-resistant, insecure-avoidant, or insecure-ambivalent attachment, through target programs is evidence-based and well documented (van IJzendoorn 1995, Centre for Parenting & Research 2006). The CfC programs offered through ac.care Murraylands directly address manifestations of interrupted attachment that subsequently decrease levels of vulnerability for children. This is achieved by working with parents and children using evidenced-based parenting and early childhood interventions in targeted and supportive play groups, that assist in the development of new positive responses to behaviours that enhance the parent/child relationship and can have lifelong impacts for the children and their families' (van IJzendoorn 1995, Centre for Parenting & Research 2006). Consequently, programs delivered by the Aspire Child Development and Wellbeing, are collaborative, inter-disciplinary, and professional programs that provide an environment that supply consistency, professional supervision, personal support, and commitment to the development of

productive, positive and therapeutic relationships with the parents, caregivers and children participating in the programs.

The ac.care Aspire Child Development and Wellbeing program reflectively and responsively engages with these aspects of program delivery and this is acknowledged in the results section of this report. Additionally, the Aspire Child Development and Wellbeing program has responded to community needs to involve parents, grandparents and carers of children ages 0-5years. Furthermore, the Aspire Child Development and Wellbeing program promotes and models interactions between fathers, mothers, care givers and children based on a 'strengths based model' of interactions thus emphasising a range of skills processed by parents/care givers and seen as enabling positive paternal and maternal care.

Targeted relationship based programs

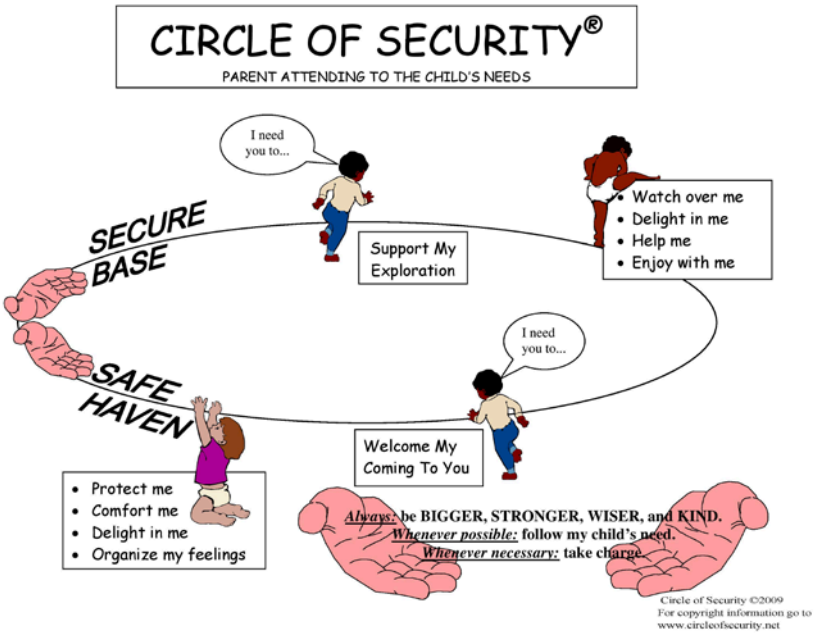
The Aspire Child Development and Wellbeing programs although initially parent and caregiver focused has expended due to community demand to incorporate other professionals providing services either directly or indirectly to children. The parenting and staff development program aims to broaden the adult's abilities to deal with challenging childhood behaviour, such as food refusal and modernise adults views of children and childhood, to encompass child development, different relationship based parenting styles, and respond to child in a relational manner that engages with, and targets problem behaviours. The ac.care Aspire Child Development and Wellbeing preventative interventions are also based on the targeted relationship based approaches to parenting and family support. As per the discussion in the introduction section of this report, targeted relationship programs recognise the importance of early child development, the social determinants of health and accumulative harm of childhood adversity (Mackintosh, White et al. 2006, Noble-Carr 2007, DoCS 2009, Keys 2009, Dockery, Grath et al. 2010, Gibson and Johnstone 2010, Solar and Irwin 2010, Marcynyszyn, Maher et al. 2011, Nelson and Mann 2011, Kilmer, Cook et al. 2012, McCartney 2012, McCoy-Roth, Mackintosh et al. 2012, Zlotnick, Tam et al. 2012, Coren, Hossain et al. 2013, Embleton, Mwangi et al. 2013, Roos, Mota et al. 2013, Kuehn 2014). Targeted relationship based programs have been effective in decreasing emotional and behavioural problems in children (Wyatt Kaminski, Valle et al. 2008). Several behavioural disorders can be addressed using targeted relationship based programs and these include:

behavioural conduct disorder, oppositional behaviour, attention-deficit hyperactivity disorder, and anxiety disorders (Wyatt Kaminski, Valle et al. 2008, DoCS 2009).

Circle of security

The ac.care Murraylands, Aspire Child Development and Wellbeing program delivers a program that includes the circle of security as a theoretical basis for evidence based practice and uses the practical activities provided by the circle of security training, such as the recognition of the child's needs to explore and return, and the parents need to engage with, and respond to, the child (Dolby 2007, Dykas and Cassidy 2011). The circle of security is an internationally based early intervention program based on attachment theory and relationship theory (Dolby 2007). The circle of security is one component of the many relationships based type programs used in the ac.care program as described in the introductory section at the beginning of this report. The circle of security theory explains the importance of secure attachment and relationships for early child development. Acknowledging that child development is ongoing, not linear and dependent on quality caregiver relationships (Dolby 2007, Dykas and Cassidy 2011). The theory is based on international academic research which confirms the key role of the use of increased empathy towards children and childhood as well as developing enhanced attachment between parent and child (Dolby 2007, Dykas and Cassidy 2011). Additionally, the use of complementary programs or foundationally similar programs, such as target relational programs, attachment, circle of security, Bringing Up Great Kids, or responding to trauma interventions, enhances the broader improvement in challenging childhood behaviours and the development of productive parenting skills. Woods (2007) outlines that recent improvements in parenting interventions for vulnerable families must include interprofessional and multi-professional services that directly address the recent theoretical advances that challenge the use of singular interventions and developmental theories.

Figure 2.1 The circle of security: attending to children's need



The figure 2.1 above is used as a basis for the Aspire Child Development and Wellbeing program and explains the interactions between child and parent/care giver. The use of diagrams, theoretical information, and easy to understand language ensures that the programs are accessible for a variety of parents and care givers regardless of their literacy, socioeconomic, and cultural backgrounds.

Bringing Up Great Kids

The CfC Murraylands Aspire Child Development and Wellbeing program uses the Bringing Up Great Kids (BUGK) parenting program as a basis for evidence informed activities (Australian Childhood Foundation 2011, Hunter and Meredith 2014). The BUGK draws on the evidenced about the importance of attachment and the use of mindfulness parenting (Australian Childhood Foundation 2011). The BUGK program contains a manual and research evidence inform reports to be used by practitioners working with traumatised parents and children (Australian Childhood Foundation 2011, Hunter and Meredith 2014). The program uses a neurobiological informed child development framework and reflective,

nurturing and mindfulness parenting (Australian Childhood Foundation 2011, Hunter and Meredith 2014). This provides parents with the information and skills needed to change parent attitudes and behaviours (Australian Childhood Foundation 2011, Hunter and Meredith 2014). The BUGK programs has been found to be effective in increasing family interconnection and emotional articulation, parental confidence, thus reducing family conflict (Australian Childhood Foundation 2011, Hunter and Meredith 2014). The BUGK program has been proven effective for parents of children with Autism Spectrum disorders, trauma histories, behavioural issues, and parents with mental health issues, substance misuse, and parents with children who have been removed from their care (Australian Childhood Foundation 2011, Hunter and Meredith 2014). Along with an effectiveness for dealing parents from 'at risk' groups, such as Aboriginal and Tosses Strait Islander parents, teens parents, and Refugee and immigrant parents (Australian Childhood Foundation 2011, Hunter and Meredith 2014).

Previous research into abuse and neglect has found that exposure to childhood adversity has lifelong consequences (Australian Childhood Foundation 2011, Broadley, Goddard et al. 2014). The BUGK programs address the impacts of abuse and neglect for the parents and children (Australian Childhood Foundation 2011, Broadley, Goddard et al. 2014). Additionally, the BUGK program collects quality data that supports the effectiveness of the program in addressing the complex issues that place children at risk (Australian Childhood Foundation 2011, Broadley, Goddard et al. 2014).

Background: Hanen Early Language Program

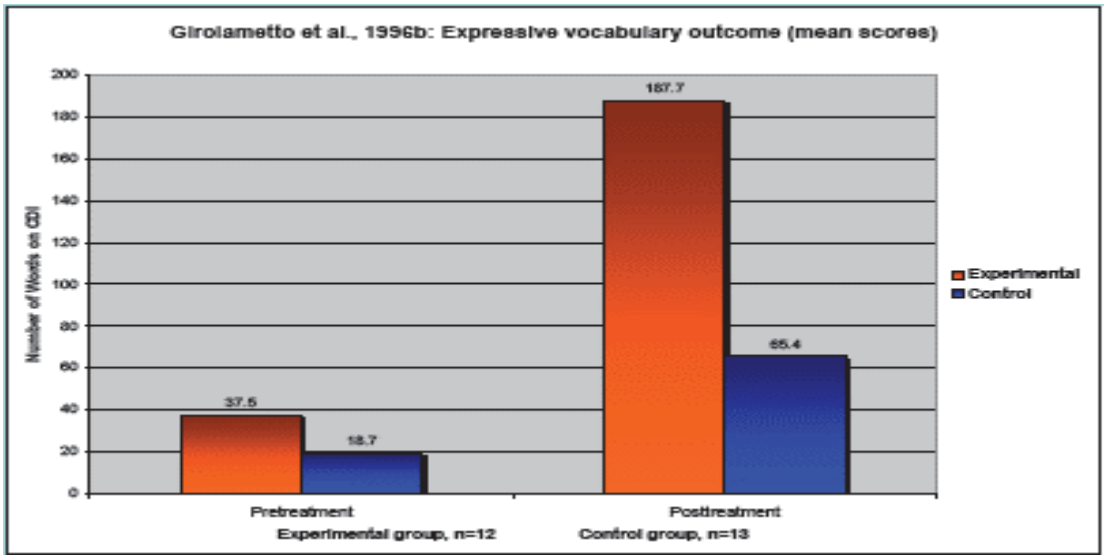
Vygotsky (1978) stated that child cognitive development occurs through language and pretend play. Ongoing research has supported Vygotsky's findings and theoretical assertions (Finangy and Target 1997, Astington and Jenkins 2008, Rentzou 2013). Pretend play and use of language are central to children's social, emotional, psychological, and physical development (Astington and Jenkins 2008, Rentzou 2013). Language development, play and attachment are also foundational in the development in the locus-of-control children required to achieve developmental milestones in school and adulthood (Finangy and Target 1997). Key to early social development and successful social relationships is the development of a communication and language skills for each child (Finangy and Target 1997). The evidence-based Hanen Early Language Program incorporates pretend play, early language development, and strategies for parents to enhance and promote appropriate communication,

social and language development prior to kindy and school. Early childhood is an important developmental period for the intersection between children's emotional processing, language, and cognitive augmentation (Havighurst, Wilson et al. 2009). The evidence-based internationally researched and delivered program provides key skills to infants and children in periods of developmental and social transition, namely, prior to school thereby enhancing the preventive intervention (Havighurst, Wilson et al. 2009). The Aspire Child Development and Wellbeing program has developed over several years to incorporate the aspects of the Hanen evidence-based programs described above in a manner that directly addresses the areas of specific need in the rural community it serves.

Hanen: 'It Takes Two to Talk' Early Language Program

The Hanen 'It Takes Two to Talk' program is delivered by a Hanen Certified Speech Pathologist (Hanen 2016). The program is internationally recognised as an evidence-based intervention for young children with speech delay and other language problems. The program is delivered to smaller groups of parents to provide targeted interventions that directly address communication and language deficits that can impact on later schooling. The inclusion of the parents in developing children's communication and language skills in an integral part of the Hanen 'It Takes Two to Talk' program. The parents are trained in strategies that assist the child in meeting their language and communication development goals. The program has consistently and effectively used parents to deliver the interventions, as this process enhances the parent/child communication, interactions, and relationship (Hanen 2016). The Hanen: It Takes Two to Talk is based on: a social interactionist perspective of language acquisition, which views the development of communicative competence within a framework of early caregiver-child interactions reflecting the interactive processes of language acquisition (Hanen 2016, p2). The graph below illustrates some of the experimental evidence for the use of the Hanen program (Hanen 2016). The Hanen research used randomise control trials to verify the improvements in vocabulary, language, social and parent/child relationship. The subsequently research by numerous scientific have supported these findings.

Hanen 2016 Research Summary: Randomised Control Trial.



The graph above illustrates the significant change in the experimental group when compared to the control group post Hanen 'It Takes Two' program intervention. It should be noted that all staff engaged in providing the program offered by the ac.care Aspire Child Development and Wellbeing program have received training the each of the theoretical areas. Along with the practical application of the theories into activities for children and parents. The structure of the programs provided are updated annually to ensure compliance with the latest research in the areas of attachment theory, circle of security and Hanen It Takes Two to Talk. Further, the Aspire staff receive ongoing training in the theoretical and practical comments of their work. Another complimentary and foundational practice delivered to all participants (parent and children) is the use of Trauma Informed Principles of Child Care.

Introduction and background: Trauma informed principles of child care

The ac.care Aspire Child Development and Wellbeing program uses trauma informed principles of child care to guide the program sessions and parent/facilitator interactions. This framework and foundational principles ensure the delivery of the program responds appropriately to any families that may have experienced trauma. Traumatic experiences are common in Australian society being the result of multiple adverse events, such as racism, family violence, war, poverty, homelessness and isolation, and are experienced across the lifespan (CFCA website 2017, SAMHSA 2016). The outcomes of traumatic experience are often serious and deleterious and therefore, need to be provided for in human service delivery

organisations to prevent compounding traumatisation. Failure to address trauma will exacerbate the trauma alternatively using trauma based principles on those who have not experienced trauma has no adverse effects. Therefore, ac,care managers, facilitators and human services delivery staff use trauma informed principles in; workforce development, and collaboration between consumers, professionals, and service providers to meet the needs of the community across service systems.

Trauma informed care

An essential component of trauma informed care is that the interventions and services provided do not inflict any additional trauma on the person, or reactivate their past traumatic experiences (Hodas, 2004, p6). Importantly, this is ensured by the consideration of trauma needs across all the systems and services involved, not just, for example, refugee, adult or mental health settings. Ac.care Murraylands and the Aspire Child Development and Wellbeing program have recognised and implemented trauma informed approaches to programs and services delivery, thus preventing the re-traumatisation of individuals, especially children, using the services. The Aspire Child Development and Wellbeing program delivers programs in a manner that uses trauma informed principles of service delivery. This practice addresses possible trauma that may be present thus reducing aspects of possible re-traumatisation of children. It is not always possible to know a child's trauma history prior to attending the Aspire Child Development and Wellbeing program therefore, using trauma informed principles is best practice service delivery.

Trauma informed care meets the individualised needs of each person. It aims to understand the trauma and the impact on the person's life, eliminating restrictive practices such as seclusion and restraint, and creating compassionate, non-coercive settings. Everyone, including staff and consumers who have not experienced trauma, benefits from trauma informed approaches to service delivery.

Trauma-informed care could be described as a framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives and their service needs (Harris & Fallot, 2001). This requires consideration of a person's environment beyond the immediate service being provided and of how their symptoms and presentations may be seen as adaptations to trauma rather than as pathologies (Herman, 1992). At the broadest level, trauma-informed care means that services have an awareness and sensitivity to the

way in which clients' presentation and service needs can be understood in the context of their trauma history (Knight, 2015). Kezelman and Stavropoulos (2012) noted that trauma-informed health and welfare settings, and systems, contrast dramatically with traditional settings and systems as they require different ways of operating, and without this understanding, risk re-traumatising service users. Trauma-informed approaches to care could be described as a strengths-based framework that is responsive to the effects of trauma (Bateman et al., 2013).

Principles of trauma-informed care

Principles of trauma-informed care have been articulated in a range of academic literature and guidance publications (Elliot et al., 2005; Hopper et al., 2010; Jennings, 2004; Kezelman & Stavropoulos, 2012; SAMHSA, 2014). These principles vary in length and number depending on the publication but essentially have the same underlying philosophies, that trauma-informed care means services are trauma aware, safe, strengths-based and integrated. For an example, of an Australian model of trauma-informed care, see Tucci and Mitchell's (2015) outline of the basic understanding of trauma that informs appropriate care underpinning the services and training provided by the Australian Childhood Foundation: *9 Plain English Principles of Trauma Informed Care* (link is external) <www.childhood.org.au/blog/home/2015/april/trauma-informed-care>.

Therapeutic Models of Care

ac.care Aspire Child Development and Wellbeing preventative interventions (objectives)

The Murraylands Rural Region has been recognised as an area where a larger percentage of children can experience high rates of developmental vulnerability (Australian Early Development Census 2015). The Aspire Child Development and Wellbeing program is delivery by speciality Occupational Therapist and Speech Pathologist child development specialists. The ac.care Aspire Child Development and Wellbeing delivers a four-part intervention program which consists of:

1. ‘Getting Ready for Kindy’ program
    a. Working directly and therapeutically with parents and children in a group setting
    b. Working individually to increase the parent’s understanding and knowledge on child development

c. Working individually to directly address parental concerns' and 'behavioural issues' such as fussy eaters, toilet training

2. Parental skills development: 'Circle of Security', 'Sensory Talks' 'Playtime', 'Bringing Up Great Kids', 'Communication Development', programs are all interwoven throughout the Aspire Child Development and Wellbeing program sessions.
3. Professional development series: are a series of developmental educational sessions provide knowledge and understanding of young children's developmental needs, and provide strategies for professionals to use with parents to assist young children to meet their developmental milestones.

Play is crucial to the development of children's gross and fine motor skills along with development of language, cognitive and social skills. Parents often notice only the development of the gross and fine motor skills (see themes in the findings section), however along with the motor skills the children meet the other developmental milestones. Through play, children practice and perfect control and coordination of large body movements, as well as small movements of hands and fingers. Child care providers and parents can support young children's motor development by planning play activities that provide children with regular opportunities to move their bodies. The Aspire Child Development and Wellbeing program provides evidence-based early interventions that address the developmental needs of young children. Additionally, communicating effectively and appropriately to children 0-5 years is imperative in the development of language, reading and neurological development. The parents are guided in the use of early learning, development and language skills.

Activities to Support Gross Motor Development

Gross motor skills involve control of the arms, legs, head, and trunk. The Aspire Child Development and Wellbeing program provides parents and carers will skills that help children to develop gross motor skills and build on opportunities for children to:

- run
- jump
- hop
- throw and catch
- climb up, down, over, under and through things
- pedal tricycles or other ride-on toys

- push and pull
- dump and fill

Specific activities that support gross motor development include running at different speeds, jumping rope, playing hopscotch, tossing and catching balls of different sizes, pitching bean bags, climbing in many different directions, pedalling riding toys, pulling wagons or toys, pushing toy strollers or brooms, and filling and emptying buckets and other containers. Remember that gross motor development happens inside as well as outside. A crawling tunnel, ride-on car, or pull toy can help children practice large movements of their arms and legs.

Activities to Support Fine Motor Development

Fine motor skills involve the careful control of small muscles in the hands, feet, fingers, and toes. Controlling the muscles of the tongue and lips to speak or sing is also a fine motor skill. Parents and carers are assisted by the Aspire Child Development and Wellbeing program in planning activities that encourage children's developing fine motor skills. The Aspire Child Development and Wellbeing Allied Health Professionals model activities that promote some of the following activities that practice hand and finger coordination:

- play dough or clay with plastic tools such as scissors or cookie cutters to form into various shapes
- blocks of various sizes to stack and arrange
- beads, macaroni, rigatoni or wheel-shaped cereal to string on yarn or shoelaces
- puzzles with varying size handles or knobs
- scissors, paints, brushes, markers, crayons, and large chalk that are all child-safe

Parents often lack models of care for children that meet all of the child's developmental needs. The Aspire Child Development and Wellbeing program models the provision of skills that enhance and improve the child's development and transition to kindergarten and school. Activities, such as shared reading encourage fine motor skills. Encourage children to turn the pages of a book and listen to language.

Each of the components incorporate activities based on validated methods of engagement, group therapy and recovery that have developed over time in consultations with the families receiving the Aspire Child Development and Wellbeing program. These strategies promote maternal and paternal infant attachment and support the reduction of family dysfunction.

Importantly, the program is free at point of use and includes inter-sectoral and inter-professional delivery. As it actively seeks to liaise between health, education, and social support services delivered by the Occupational Therapist and Speech Pathologist, with inputs from mental health and child development via referrals to experts on the inter-professional collaborative methods of delivery and referrals that are important to the outcomes of the intervention. This ensures the program provides a cost-effective service model, as it brings together long standing effective pre-established pathways of care, networks, and sponsored community supports in an evidence-based practice model of care to address the specific needs of families dealing with disadvantage, poverty and social isolation.

In keeping with evaluative research methods this section of the research project sought to elicit both the quantitative and qualitative perspectives of the broad range of stakeholders engaging with the Aspire Child Development and Wellbeing program. The stakeholders included: program managers, mothers, and community staff. This report discusses the findings of this evaluation.

Models of service delivery (applying the theories)

The aims of the Aspire Child Development and Wellbeing program

The Aspire Child Development and Wellbeing program uses several models of service delivery. All families attending the program can assess the variety of other programs designed to enhance infants and children's early learning and development though extensive community links and referral networks. The aims and goals of the program is to use evidenced-based theories as outlined above that develop early learning strategies in infants and children, support and identify the assistance that is needed for the family to be supportive, connected and build a stronger community. The aims of the Aspire Child Development and Wellbeing program are achieved using the following activities that directly address the use of interprofessional and multi-professional services based on recent theoretical advances that challenge the use of singular interventions and developmental theories. The aims are outlined below:

- Providing parent/child interventions enhancing
    - Emotional support of children
    - Child cognitive development
    - The importance of play

    - Developing secure attachments
    - Resilience and
    - Enhancing school readiness
- Communication Talks provides parents and carers with information on
    - The development of communication
    - Language development
    - How to seek help with parenting and child development
- Toilet training (developed by Disability SA and widely used across the state for children experiencing delays in toileting).
- Sensory Talks
    - Sensory development in children
    - Sensory processing in children
    - The impacts of sensory stimuli on children's behaviour
- Support from other services
    - Speech pathology
    - Occupational therapy
    - Social worker services
    - Physiotherapy services
- Connections to
    - Kindergartens
    - Preschool
    - School
    - Referrals to
        - Centre care
        - GPs, Physiotherapy services
- Modelling positive parenting skills and strategies

These activities improve child cognitive, language, communication, and social development along with parenting self-efficacy, and are based on validated theories and methods of engagement for children aged 0-5 years. The Aspire Child Development and Wellbeing program interventions outlined above have provided significant changes and improvements in children's development and parenting and carer interactions with children (findings section below). Furthermore, the children's behaviour improves after participation in the Aspire Child

Development and Wellbeing program. Parents and carers are also more engaged in the community and more likely to participate in other parenting programs in times of need. The use of several theories and interventions, such as toilet training, provides services that are comprehensive, holistic and meet the needs of the program participants (Program Logic Appendix A).

The programs are based on sound theoretical premises, for example, Hanen It Takes Two to Talk based programs, attachment theory, circle of security parenting programs, and sensory talks. These extensive and complimentary theoretical, and evidence-based, foundation for the programs are described in the introduction and in the literature review above.

Research methods for the evaluation of the Aspire Child Development and Wellbeing Program

Stage one of the evaluation of the Aspire Child Development and Wellbeing program consisted of a literature review of the theories and service delivery models used to determine the evidence base for these aspects of the intervention programs involved. Stage Two included interviews with providers (managers and staff), community service providers (participants in the professional education program), and parents. The collected qualitative data was analysed thematically to provide in-depth understandings of the impact of these programs on the families and the community. These two stages together will provide a broader and deeper understanding of whether the ac.care Facilitating Partner initiatives provided by the Aspire Child Development and Wellbeing program, have improved the health, education and social outcomes for children and families in the Murraylands area.

Research process

The research processes have remained consistent for all the qualitative data collection throughout this research project. The initial research processes, such as inclusion and exclusion criteria, data analysis, participant inclusion etc. have been outlined in the introduction. The Aspire Child Development and Wellbeing program are also provided by professional staff with a background in interpersonal relationships, child learning, child development, and parenting programs. The professional knowledge and support ingrained in the programs ensures the interventions within the programs are theoretically sound. The theoretical base and application processes embedded within the programs provides a robust

practice consistent with the theoretical underpinnings. The information provided by the key informants adds to the validity and robustness of the programs delivered.

Section four:

Results

Background of the Aspire Child Development and Wellbeing programs

The Aspire Child Development and Wellbeing program has developed over several years and responds to the needs of the children, families and the community. Complex families addressing multiple disadvantage, such as cultural, economic, and geographic, are only successfully assisted using multiple pedagogical and theoretical interventions and educational processes (Wood, 2007). Reified developmental theories and child centred approaches to ECD learning and play have provided new evidenced-based informed practices that inform interdisciplinary program delivery and community integration (Wood 2007). The Aspire Child Development and Wellbeing program has been successful for several years in developing and delivering a high quality, inter-disciplinary intervention programs, that improves the lives of vulnerable infants and children as espoused by the policy and CfC directives.

The broader aims of the Aspire Child Development and Wellbeing program
The Aspire Child Development and Wellbeing program aims to:

1. Deliver a reflective and responsive program that address the developmental needs of children in the Murraylands community
2. Deliver evidenced based interventions and preventions based on sound theoretical and practice models that improve the developmental outcomes for children and their families
3. Ensure the family functioning of participant families is improved
4. Ensure the program is based on child centre practices.
5. Reduce the vulnerability levels for children living in an area with higher levels of vulnerability in this rural community
6. Improve the developmental language, learning, social and psychological outcomes for the children attending the program.

The aims of the program are based on the resources and theoretic models used to support parents to provide a safe and developmentally enriching environment where children can achieve their full potential. All the activities, skills and strategies provide by the Aspire Child Development and Wellbeing staff are delivered in a child centred practice manner. This reinforces the importance of children and the consideration of children in all aspects of the programs.

Findings

General information
The Aspire Child Development and Wellbeing program has engaged with the Murraylands community for several years. It's success can be attributed to its engagement with the community and the balance of theoretical evidence-based program and meeting community needs. This is reiterated by the increasing numbers of participants attending the program and the comments in the themes section of this report. The interprofessional and multi-professional services provided in the Aspire Child Development and Wellbeing programs directly address the recent theoretical advances that challenge the use of singular interventions and developmental theories. Table 4.1 below provides an overview of the attendance levels for the Aspire Child Development and Wellbeing program and the numbers of isolated families serviced by the programs.

Table 4.1 Mothers and Children attending the Pathways Program now known as Aspire Child Development and Wellbeing program

Year	Participant Type	Numbers	Basis for participation
2009 (1st July to Dec)	Total	160	Various parenting programs, 'little Buzs" and information sessions offered through Pathways Program. A pool of 18 staff were required to deliver the programs. Programs were also funded for 5 days a week service coverage.
2010	Mothers	231	Continued to be delivered through Pathways Program with a pool of staff in the Children and Families Team. Contracted Community Partner Murray Mallee Community Health
	Children	80	
	Total	311	
2011	Mothers	269	Play group and information sessions run by OT and Speech Therapist continue. Child development Sessions delivered to parents and professionals working with children (25 young parents involved)
	Children	170	
	Total	439	
2012	Mothers	234	Play group and information sessions run by OT and Speech Therapist continue. Child development Sessions delivered to parents and professionals working with children (30 young parents 20 to 25yrs involved) (5 young parents under 20)
	Children 5-12	166	
	Total	400	
2013	Mothers	239	Play group continues in Mannum, a range of child development sessions are delivered to parents and professionals working with children. (10 isolated families participate) the CFC model changes and it is no longer possible to fund State organisations, SA Health have also changed their guidelines and can no longer work in the CFC space.
	Children 5-12	140	
	Total	379	
2014	Mothers	47	(17 families participate) play group continues for the six-month transition period delivered by the FP. This was a good opportunity to talk to parents and they highlighted the need for experts trained in child development. The extremely poor results of the AEDC in this region also was considered in this process. Conversations took place with OT and Speech Therapist and Aspire – Children's Wellbeing and Development Partnership formed.
	Children	56	
	Total	103	
2015	Mothers	34	Please note that numbers are now less due to funding allocated and ability to deliver playgroup fortnightly because of this. Aspire – Getting Ready for Kindy sessions continued to a lesser extent as we were no longer able to fund a CP 5 days per week but needed to continue offering some child development services.
	Children 5-12	36	
	Total	70	
2016	Mothers	23	In 2016 Aspire delivered playgroup only and extra parent sessions/professional development sessions
	Children	24	

Year	Participant Type	Numbers	Basis for participation
	Total	47	did not take place. (total of approx. 38 hours per year)

Table 4.1 above provides an overview of the Aspire program. The program began in 2009 to help prevent child abuse and neglect in 160 rural families, and has continued to 2016 to serve only 47 families. In total the Aspire program and its former iterations has assisted 1,530 families to provide improved care of their young children and prepare the children for school. In recent years, the numbers have decreased from the maximum of 439 in 2011, to the 47 families in 2016, due to successive funding cuts. The need for the Aspire program continues to increase, as does the need of the young children in this area for such a program, and this is supported by the foundational work of Fegan and Bowes who state:

> *" All families, including those living in urban areas, need access to information that helps them gain a realistic understanding of their child's development and of the possible impact of developmental changes on family life. Families living in isolated circumstances, but particularly geographical isolation, are often deprived of incidental encounters with other children and other parents within the local neighbourhood, encounters that can provide such information, reduce the intensity of uncertainty and alleviate parental anxiety."*
>
> *(Fegan and Bowes, 1999).*

Along with the evidence based program delivered by the Aspire Child Development and Wellbeing program meets the needs of this rural community by directly addressing problematic child behaviours and parental anxieties using the premise espoused by Fegan and Bowes (1999) above. The current program delivered in 2017 is well utilised and addresses an urgent area of need within the community. The Aspire Child Development and Wellbeing program uses The Goal Achievement Tool to collaboratively determine (with the parents) the therapeutic interventions required for the children to meet their developmental goals. For example, children aged 0-5 can exhibit behaviours such as spiting, biting, or experience food refusal, food fussiness, and significant aversion to certain food textures, smells and tastes. These behaviours can make integration into school unnecessarily difficult. The Aspire Child Development and Wellbeing program provides practical strategies based on children's developmental needs that are child-centred and strengths based to build parental capacities and abilities. These attributes are captured in the thematic analysis section.

The other series of Aspire Child Development and Wellbeing programs is delivered to community professional staff to expand the local area knowledge and understandings of child development and developmental needs. This education series recognises the exemplary skills and knowledge base of the two professionals delivering the Aspire Child Development and Wellbeing program. Community sector staff attending the educational sessions have been interviewed and provide feedback on the usefulness to their professional practice of the education sessions. The responses are included in the qualitative analysis results presented in the thematic findings below.

Table 4.2 below illustrates the types of participants involved in each stage and step of data collection. The table 4.2 also highlights the method of data collection required for each participant type. The basis for recruitment outlines the role of the participants and implies their level of involvement in the Aspire Child Development and Wellbeing program. Additionally, table 4.2 provides an explanation for the type of data collected and the level of involvement of the participants. The Aspire Child Development and Wellbeing program has developed a reputation (see themes section) for assisting parents in developing and maintaining a positive and productive relationship with their children through activity. The methods used in the data collection inform the analysis used in the evaluation. Table 4.2 illustrates the types of participants involved in each stage and step of data collection. The table also highlights the method of data collection required for each participant type. The basis for recruitment outlines the role of the participants and implies their level of involvement in the Aspire Child Development and Wellbeing program.

Table 4.2: The type of participants and method of data collection used

Participant Type	**Numbers**	**Basis for Recruitment**	**Component of Research Involved In** (e.g. survey, interview, focus group, observations)
Providers (managers and staff) (S)	3	Responsible for delivering the CfC Aspire Child Development and Wellbeing program programs.	Focus group interview. Staff also provided observational information (on behavioural changes in families and children), or phone interview.
Community partners (CP)	2	Aspire Child Development and	Face-to-face/phone interviews.

Participant Type	Numbers	Basis for Recruitment	Component of Research Involved In (e.g. survey, interview, focus group, observations)
		Wellbeing staff refer to these organisations	
Parents (P)	24	Participated in the Aspire Child Development and Wellbeing program	Focus group, and Face-to-face/phone interviews.
Health, Human Services and Educational Professionals, such as primary school teachers (OS)	4	Participating in the ongoing Professional Development programs.	Face-to-face/phone interviews.
Survey participants	46		
Total	**69**		

The Aspire Child Development and Wellbeing program staff and parents were interviewed as per table 4.2 above. The table 4.2 illustrate the role of each participant and the component of responses provided by each participant, such as interview. The component was organised by the researcher in accordance with the participants wishes and convenience. All interviews or focus groups were conducted in a private and safe place. The theoretical links discussed during the interviews included attachment theory, Hanen It Takes Two to Talk, ECD practices, circle of security, and trauma informed principles of service delivery are explained in previous sections of this report. The information collected outlines the intensive support provided by the Aspire Child Development and Wellbeing program assisting families and their children to deal with social and cultural.

Goal Achievement results of the children attending the program

The Aspire Child Development and Wellbeing program assesses the young children attending the program to determine the individual needs of the child and family. Any deficits in behaviours, languages, cognitive and social skills deficits that are identified by the staff in their area of expertise are addressed collaborative with the parents. This requires upskilling the parents to enhance the areas of need in the child. This process also improves the parent/child relationship and the child's capacity to learn and prepare for the requirements of school which include social interactions along with language and cognitive abilities.

The Aspire Child Development and Wellbeing program uses proactive, complete, targeted and inclusive community based program delivery. The Goal Achievement Tool is used collaboratively with parents to design strategies for parents to achieve to address areas of the child's behaviour that is of concern highlighted by the parents. The goal sheet (in appendix F) is scored as follows:

- Parents identify the behaviour to be addressed
- Children score 0 if the gaol is achieved and higher e.g. +2 if a behaviour has improved above the expected or usual improvement in behaviour
- The measurement scare represents the extent of improvement for that child with 0 = normal chid development for a child of the age

Every child attending the Aspire Child Development and Wellbeing program is assessed using the Goal Achievement Tool and a small sample of the usual results obtained for the program appears in Table 4.3. Following participation in the program the results are provided to the parents. The results of a limited number of Goal Achievement tools are presented in Table 4.3 below:

Table 4.3: Aspire: Joining The Dots, Goal Achievement Tool measurement outcomes

Participant	Age	Goal achievement + score	Comments from parents
1A (child A), (term 4) 2016	4	YES +2	Behaviour of concern: limited and dysfunctional interactions with other children and adults (this would impact directly on school and learning). Mother has not witnessed him ever being able to participate in groups without having a meltdown before the intervention. Following the intervention, he has improved his behaviour to join in etc. - +2 improvement is an outstanding result.
		YES +2	He did not understand the concept of sharing before the intervention
		YES +2	Was getting upset whenever his hands touched sand. Didn't like messy paly. Now has improved better than expected.
1B (term 4) 2016	4	YES +2	Very shy and hesitant especially when mother not around. This behaviour has improved beyond expectations after the intervention. Now confident enough to initiate play with other children.
1C (term 4) 2016	4	NO -2	Very short attention span and wanders off to do other things. Same level as baseline

		YES -1	Does not know how to hold scissors with one hand and manage paper with the other.
		NO -2	Still unable to draw and write letters. Child not interested in focusing on these activities. Therefore, same as baseline measure and no improvement.
1D (term 4) 2016	4	YES =0	Able to trace letters and beginning to write name. child has begun to make appropriate letter formation following intervention. Change is as expected forage group and developmental level.
1E	4	YES +2	Child no longer shy and able to initiate play with other children. Still shy around big groups of people/children. He has exceeded expectations on this activity.
		YES +2	He can now initiate activities and sometime refuses activities. He has exceeded expectations.

Table 4.3 above illustrates the changes that have occurred from the baseline measures taken at the initial assessment. The changes above are consistent across the number of years the program has been used. These changes have occurred for some children in the program. This data is a snapshot of the interventions and the changes in skill levels expectations by each child. The skills and behaviours addressed are very important and foundational for attaining learning and other skills at school. The programs assist parents in targeting the skill and behaviour issues that are of concern to the parent. These skills enhance children's ability to achieve the most from kindy and school attendance. Along with meeting the child's normal developmental needs. The scores are a measure of achievement for each individual child with the baseline scores are mindful of normal child development levels. These children are at risk of developmental delays that will impact of their future learning and socialisation skills required to develop normally as children and adults.

Aspire Child Development and Wellbeing program staff provide education and training programs for professionals. The professionals attending the 'Sensory Processing and the Impact on Children's Learning' provided feedback on the appropriateness and relevancy of the information, knowledge and skills learnt. The results indicate that all of the professional staff participating in the Aspire Child Development and Wellbeing program staff development sessions, for example, the 'Sensory Processing and the Impact on Children's Learning' gained valuable information knowledge and skills that enhanced their professional practice as evident in figure 4.1 below.

Figure 4.1 Sensory Processing and the Impact on Children's Learning' survey results

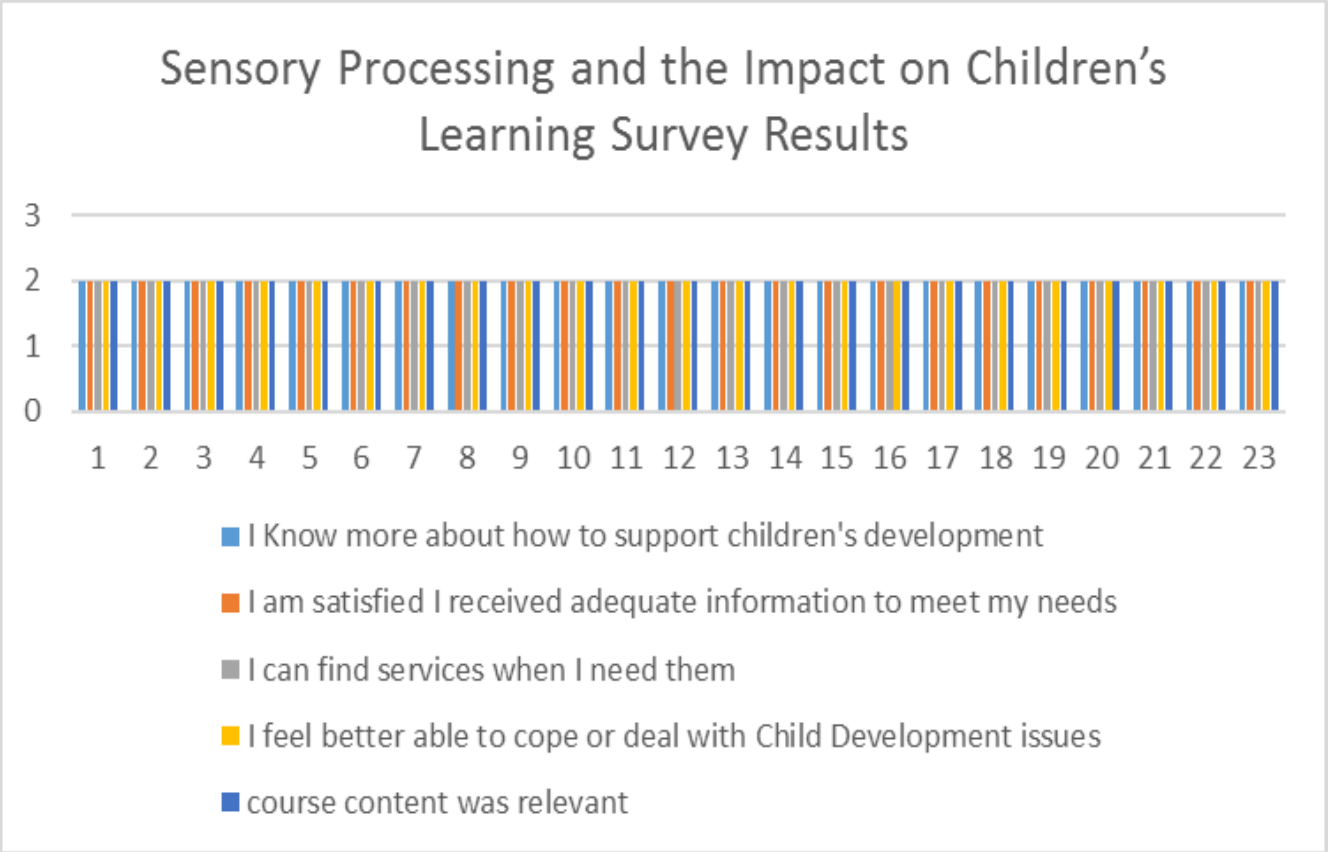


Figure 4.1 above illustrates the topic areas covered by the 'Sensory Processing and the Impact on Children's' Learning' post workshop session results. There is no pre-workshop assessment of the professional staff's knowledge on the areas targeted by the educational session. It is assumed, correctly, and as per the themes below, that the staff that enrol and attend the sessions have limited/no prior knowledge on the child development topics covered.

The use of complimentary and foundationally similar enhances the practical application of the interventions provided to parents to assist the parent in changing their child's behaviour. The literature and data collected supports the findings that these programs are, not only imperative, to the populations they serve, but also meet the broader and direct aims of the Aspire Child Development and Wellbeing program and professional staff development sessions. The use of several sources of data, informants, and information provides a robust analysis and evaluation of the Aspire Child Development and Wellbeing program.

It has established above that the use of multiple sources of information and informants enhances the validity and robustness of the findings (Parry and Willis 2013). The key informants in the Aspire Child Development and Wellbeing program were the ac.care managers, and direct delivery staff, Cathy and Melanie, who provided the theoretical knowledge and background for the program development and implementation.

Qualitative Results

Further, while method of data collection varied as the community partners, external service providers staff, managers and staff participated in face-to-face or phone interviews, and the parents participated in a focus groups, the fundament premise of questions regarding the Aspire Child Development and Wellbeing program remained the same. Additionally, the Aspire staff participated in a small focus group and provided further data and information in follow up interviews via the phone for the clarification of some of the data and information provided. The parents participated in small focus groups or face-to-face/phone interviews. The main themes arising from the interviews and focus groups are summarised below.

Themes

It is imperative to remember that there is a dearth of services in the Murraylands area. There were six main themes found within the data. Data saturation was achieved in all the area presented below. Interestingly, there did not appear to be any difference in comments between the Aspire program staff and managers, community partners, the external services providers attending the professional workshop, and the parents on the effectiveness of these programs in delivering support that addressed aspects of the child behaviour, and changed the participants, and their care of children in their lives for the better. This is a unique high quality program. The use of multiple sources used from a variety of perspectives increases the robustness and validity of the responses. The use of narratives ensures the richness and the depth of the responses. The themes presented below are in order of importance within the data with theme one being more prevalent than theme two etc.

Theme 1: Preparing Children for Kindy and School

The views presented in this theme have been derived from all participants. That is the staff, managers, community partners, and parent's/caregiver's views are acknowledged here. In

many instances, there were positive comments about the comprehensive nature of the individual support, parenting support and supportive links provided by the Aspire Child Development and Wellbeing program through the parenting advice and changes, supportive modelling techniques, child behaviour change techniques, managing stress strategies for children and adults, and referrals to other community providers. Further, there were positive comments claiming that the Aspire Child Development and Wellbeing program had driven changes in the parents lives that would not have been achievable without the program. Examples included being able to 'sit and listen' and 'learn new things' with their children in developmentally meaningful ways which did not happen prior to the parents attending the programs. The quotations below reflect the managers and staff (S), professional education sessions provided to other external services (OS), community partners (CP), and parent's/caregivers (P) responses to participating in the Aspire Child Development and Wellbeing program:

The Aspire Child Development and Wellbeing program provides routine for young children…this is sometimes missing in vulnerable families where there maybe chaos which decreases the child's ability to learn (S1).

The routine for young children prepares them for learning activities, play activities and school preparation activities. It assists with normal child development and decreases levels of vulnerability (S2).

They [staff] use the bell to sit down so the kids know what to do…the routine is great…they listen to the teacher (P1).

The kids learn to use scissors, get dressed, toilet training and these things are really difficult to teach kids…the kids need these skills for school (P3).

Our staff have gained so much knowledge from the Aspire ladies, the change in the depth of our knowledge and support of families wouldn't be there without the Aspire workshops for staff. Our staff can now support the parents and children in the child's learning and that wasn't there before this workshop. Their [Aspire staff] knowledge of the local area and the places/people to refer the families to is astounding. The Aspire staff have also helped inspire our staff to learn more and contented our staff to other courses with qualifications etc. (OS1).

The knowledge and help provided in the workshops [Aspire] is fantastic. In one example, we had a staff member go from single mum to university and then to qualify as a professional to work with children. It's not a direct aim of the Aspire workshop for

our staff, but it was a spinoff, the staff member, a young woman, who was so impressed by their [Aspire staff] knowledge, insights, understandings, and strategies used to help parents, that it inspired her [staff member] to go to uni and become qualified (OS2).

The skills provided by the Aspire Child Development and Wellbeing program are foundational for the best start at Kindy and school. The complimentary and interwoven theoretical basis of the program informs the delivery of skills for external service providers, such as Minya Porlar Crèche, parents, and young children that promotes fundamental learnings for good Kindy and school integration. Along with the delivery mode that ensures a holistic and wrap around individualised service delivery model. The staff assess the needs of each child and parent, and direct the activities to meet the language, social, learning and developmental needs. This process also includes a focus towards an overall end-point of preparing the young children for entry into Kindy and school.

The Aspire Child Development and Wellbeing program also provides knowledge on children's developmental milestones, such as fine and gross motor skills. The staff modelled exemplary parenting and attachment behaviours and provided one on one support for parents having difficulties with parenting skills. Further, the interaction in the Aspire Child Development and Wellbeing group allowed the parents to explore their difficulties, anxieties and concerns around parenting and other social interactions thus improving social connections. The Aspire Child Development and Wellbeing staff often addresses severe behavioural issues. Furthermore, the Aspire staff provide educational and training sessions for professional staff from other organisations in the Murraylands region. This has been a response to the lack of advanced education and training in the area. Education and training sessions, such as 'Sensory Processing and the Impact on Children's Learning', was described by one OS manager as a 'god send in the area'. The only complaint was that the professional education and training sessions did not happen often enough for the service. Therefore, Aspire Child Development and Wellbeing program is flexible enough to attend to the needs of all the participants, parents and professionals alike, and this is a reflection of the robustness of the program and the professionalism of the staff. The Aspire Child Development and Wellbeing program directly address behavioural issues in young children to provide an early intervention to help minimise the impact of these issues on children's ability to engage with others and learn. The theme of behavioural issues is illustrated below:

Theme 2: Behavioural issues in young children

The views presented in this theme derive from all participants. Thereby, acknowledging the views of the external service providers (OS), managers and staff (S), community partners (CP), and parents (P). The participants had found the Aspire Child Development and Wellbeing program provided information, expertise, and knowledge on the behavioural issues that occur in young children and strategies to address these issues. The strategies can be used by the parents and other professionals in the community. The comments below reflect the positive changes to the understanding of behavioural issues for parents and community providers:

> *There are various levels of behavioural issues in the children attending…including developmental issues, and skills deficits, for all the age groups. We address these with strategies we have development over the years based on the extensive training we have received and each session has a strong theoretical base (S1).*
>
> *The Aspire Child Development and Wellbeing staff are fantastic you can tell they are professionals [one is a speech pathologist and the other an occupational therapist]. They [Aspire staff] provide educational sessions for the staff here [Kindy], health staff, like nurses and other professionals in the community. They [Aspire staff] are so knowledgeable on what works with kids who have very challenging behaviours…what works with kids who have witnessed domestic violence. It is terrifying to think that at aged 3 some of the children coming here have seen a parent murdered, or DV (CP1, OS2).*
>
> *I didn't know what to do my son refused to toilet train, I thought we would end up sending him to school in pullups…but Cathy and Melanie [Aspire staff] fixed it…they are so understanding and helpful. It might not seem like much but it has changed our life (P6).*
>
> *My son has autism …he spits on people…it's gross…they [Aspire staff] have given me skills on how to deal with his behaviours…it has changed our life around. It's much better at home now…we had been to other services before and they [other services] did not give us anything that was useful (P7).*
>
> *My daughter bites…if you do something she doesn't like, she bites you…I've tried everything to get her to stop and coming here, Cathy and Melanie [Aspire staff] are so*

calm and helpful, and redirect her behaviour…and have given me skills to deal with it. We couldn't have people over before or other kids, she would bite them (P10).

Parents (and other professionals) come with questions about their child's behaviour…it's very important that it is run by allied health professional, we have more knowledge [education levels and decades of experience], know the evidence and can provide direct referrals. Allied health professionals provide a strong foundation for dealing with behavioural problems, autism etc. and getting parents to connect with their children. Early intervention is very important in addressing these issues before they get to school. At school it's too late, and the behavioural issue then impacts on their learning, and they fall further, and further behind. But here we address it early and get them ready to learn (S2).

Parents are concerned that perhaps their child won't be ready [for Kindy or school], not meeting developmental milestones like toilet training…we help the parents to help get the child ready. We give the parents the skills and know how to progress the child through their developmental milestones. We can help the parent to understand 'normal' development and skills…we provide individualised developmental information and skills it works much better than generic information. We have the background education and professional knowledge to do this (S1).

We get asked to manage behaviour all the time…sometimes the children may have disabilities the parents don't realise…we have a professional background so we can do our level of assessment for them [child], with our experience, knowledge, and background, we know who to refer them to, or what to help the parents with and to do with the children to improve their development…we provide a tailored program. We are always respectful and work collaboratively with the parents at all times, especially with interventions, and referrals, and we follow up as well with the parents to make sure their needs are met (S2). (these comments were supported by all the parents, OS and CP interviewed).

There are some children we are very concerned about…their behaviour. We have extended conversations with mum to get help…we get support for the children early then…early in the life of the behaviour, or problem, issue. Then it has less impact and doesn't interfere with development. We liaise directly with the Kindy and discuss the

vulnerability and developmental delayed children. We help the Kindy staff manage difficult behaviours too (S1). (This comment is supported by CP1, CP2, OS1, OS3).

It's very professional here…very well organised and done. The kids learn a lot through play and know how to get on with other kids. That wouldn't happen if this program wasn't here. The staff are so knowledgeable and professional and can keep things confidential and other groups elsewhere don't do that...they [Aspire staff] help get you other professional help as well. The kids learn how to get on with other kids. It's also individualised they [Aspire staff] pitch the lessons at each child's behaviour, level and their needs…they [Aspire staff] know their needs. It helps their [child's] development (P6).

The comments above highlight the pivotal importance of having highly educated and trained allied health professionals delivering the program. The behavioural issues and disabilities identified during the Aspire Child Development and Wellbeing program would be missed by lesser qualified staff. Thereby decreasing the impact of the intervention on the child's development and the parent's ability to effectively intervene. The ability of the Aspire Child Development and Wellbeing staff to intercede early and support the Kindy staff is one of the keys to the program success. The child benefits from the early intervention as it helps to minimise the impact of the behaviour or disability on the child's future Kindy and school attendance. The intensive support provided by the ac.care Aspire Child Development and Wellbeing assists families and their children to deal with the impacts of social isolation, poverty, disadvantage, and belonging to CALD and ATSI groups. The program uses proactive, complete, targeted and inclusive community based program delivery. The results of this research illustrate the importance of this program.

Another prominent response theme was that of 'isolation'. From the literature above it is recognised that isolation is a risk factor for children, and can lead to higher incidence of behavioural problems, abuse and neglect, along with failure to meet developmental milestones. Most of the parents discussed their isolation from other families and services and the Aspire Child Development and Wellbeing program had provided a means for them to connect to others. Gaining support and understanding with issues that accompany parenting. The parents recognised that isolation had negatively impacted on their parenting capacity. The skills attained through the Aspire Child Development and Wellbeing program and

supportive staff, had helped to link the isolated families with other families, other children and their community. This enhanced the support the parents and children received. The therapeutic interventions were constructed to alleviate the impacts of issues described below. The use of the activities is specifically designed to improve the child/parent interaction and relationship while connecting isolated parents, and enhance parental attachment to their children.

Theme 3: Isolation

The views presented in this theme have been derived from the professionals delivering the program and the parents participating in the program. Isolation is a recognised risk factor for children increasing the vulnerability of the children and the family. Additionally, the method of therapeutic intervention allows the parents/caregivers to receive support from one another in a purposeful and constructive manner. These aspects are illustrated in the quotation below:

> *We live on a large farm out of town, I was so isolated, depressed, and this [Aspire] program has helped to connect me with other mums, with kids the same age. I know my parenting has improved too…I feel more confident with my parenting now, I know I am doing the right thing…we have no one else around us to help, my parenting has improved and I feel more skilled and able to cope as a parent (P4).*
>
> *We moved here, we are migrants, my husband is a doctor, it has been a great way to meet other parents and get accepted by the community. Everyone has been so helpful and friendly. I feel less isolated, I know new ways to cope and my child has improved so much it's great to see (P5).*
>
> *It helps get you out of the house…it's a huge thing, it might not seem it, but you are kinder to your kids when you're connected. You need to be out and connected to other people…the kids need it too...we support each other outside of being here…we catch up with each other. I wouldn't have that if we didn't come here and the kids would suffer (P9).*
>
> *The parents are often very isolated as they are transitioning. Transiting into being families along with other transitions as well. Families move due to work, much more than they did before…the husband has work, and they must move. The families' then lack connections, and support, and are isolated. So families can be transitory and we make the program so it suits their needs. We are very good at connecting families with*

other families, the community, and the services they need. Isolation is such a risk factor for the children (S2).

It's good for the kids to socialise as well…its very professional here…very well organised and done…it helps us deal with isolation which can be hard when you're on your own (P6).

The Aspire Child Development and Wellbeing staff are really good at dealing with families who are isolated. The families get stressed and anxious and can't connect. It's a huge issue now as families move around so much. It didn't happen when my kids were little we stayed in the same place you had support, connections (CP1, OS1).

These comments capture that for families dealing with isolation there can be stress, depression, and anxiety. According to the literature isolation is a major risk factor for infants and children. The Aspire Child Development and Wellbeing program provides the opportunity to participate in developmentally appropriate activities, such as reading, language skills, fine motor skills and an interpersonal relationship building program in a physical, psychological and social space that promotes parent/child relationships. The small group environment and one-to-one service delivery at times of parental stress, enables the parents to deal with the impact of isolation and ensure the children are connected to professionals able to handle child and parental distress effectively. The staff model opportunities to be calm with their young children and promote an environment that encourages child development and behavioural control. This is coupled with the instruction, knowledge and skills that enhance positive interpersonal support, relationships and respect.

The Aspire Child Development and Wellbeing staff and the program also incorporates dealing with trauma and domestic violence. As discussed in the literature the use of trauma informed therapeutic principles positively responds to incidence of trauma and can be used with those who have not suffered trauma as well. This is aim and finding is supported by the responses from those interviewed including professionals working at other services who have attended the Aspire training program.

Theme 4: Using the Aspire Child Development and Wellbeing program to deal with trauma and domestic violence

The views presented in this theme derive from all the participants in the Aspire Child Development and Wellbeing program along with the professionals attending the education and training program. The use of sound theories in the programs development is evident in

the positive measurable outcomes (discussed in a later theme). The trauma informed principles of intervention are useful in dealing with young children as there is often a lack of prior warning that a child has endured a traumatic experience. The benefits of this theoretically informed approach are outlined in the comments above are also expressed in the comments below:

> *We know some of the children have witnessed domestic violence or some abuse in the home…the parents disclose as we build up a trusting relationship…we refer them out and support them…we have a strong clinical base to help the children and help the parents to help their children through it. Surprisingly, it comes up quite a bit…we can connect what we see in the child's behaviour with what's happening in the child's life. We can see the child's behaviour in the context of what's happening in the family and address it directly. Every group we provide referrals, we gently steer the parents to get help for them and their children. We are very respectful and are mindful of how difficult it can be for parents to get help and trust professionals. As health professionals, we use observational formalised assessments to get them [families] help quickly (S1).*
>
> *They [Aspire Child Development and Wellbeing staff] deal with trauma really, really, well here. I want my nephew to come, and they said yes, he could. He saw his mum murdered…he's so aggressive…trying to deal with what he saw…he's only three. He bites, kicks, spits, smacks, screams poor kid…it's too much for him to deal with…it's so difficult to watch. It breaks your heart. He comes here…he has done so much. It's been good for him here…the difference has been fantastic. Now there is hope that he may be able to move on and get better with dealing with it (P8).*
>
> *The Aspire Child Development and Wellbeing staff are excellent very knowledgeable and professional. They deal with the young kids who have witness violence. It's a bigger issue than you think. You need to deal with it early on or it can ruin the kid's life and impact on their schooling. I have seen them turn a child's life around and the parent too (CP2, OS2).*
>
> *The Aspire professionals have provided training to several of our staff and it was great…we learnt ways to handle some of the more difficult behaviours, trauma in children and all the child developmental stuff. We also learnt a lot about other services and were to refer families when the behaviour problems, of the parent and child, things and places we never knew existed even though I worked in the area for years (OS3).*

We provide family day care services and our staff have attended the educational programs with the Aspire women and they are fantastic…they taught us things we did not know, we know lots of things about infants and children, but they knew different things, and gave us the strategies we can use for problem behaviours in children, and they taught us a great deal on how to deal with behaviours issues and who to refer our clients to for better help (OS1).

The discussed themes above outline the main aims of the program is to improve outcomes, relationships, behaviours and service provision for parents and children. Achieving this using qualified staff across all areas of service delivery is essential. For example, the OT and SP qualifications are essential in delivering the evidence based programs and in meeting the aims of the Aspire program. The Aspire staff are professional trained to use the all the aspects of the program being delivered, e.g. Hanen Early Language, to ensure the use of the Aspire Child Development and Wellbeing theory based program remains sound. There is also a consistency of staff used to provide the programs and this assists with consistent delivery and in building trust with this vulnerable group of parents, carers and children.

Theme 5: Modelling parenting and increasing emotional support

The use of standardised evidence based theories, such as Hanen, Attachment, BUGK, provides a sound base for the modelling of positive parenting behaviours and influences. Not only for parents but also for the staff and other professionals undertaking the Aspire programs and workshops. The tools used in the Attachment Theory, Goal Setting, and BUGK have been proven to significantly improve the emotional support and the ability of the parents to 'attend' to children's needs, along with, child language, social, emotional and behaviour improvements. The external service providers, community partners, managers and staff, and parent's positive comments claimed that the Aspire Child Development and Wellbeing program had precipitated the change in the participant's mental health and improved their relationship and bonding with their children. This is highlighted in the quotations below:

They [Aspire staff] open your eyes to how important supporting your children is for them to grow and develop. The things we can show our kids to give them new life experiences, little things, like that are very important. Like things we can show our kids, like how to talk to them [kids], talking about nature, like ants, birds, and the wind blowing on our face…I didn't know I could help my kids learn so much and connect to your kids while you're doing it…help them emotionally to develop (P13).

It different things each week…they cover the emotional development as well. I didn't know it was so important …you know, so they [child] can cope at kindy and school. They [Aspire staff] show us what to do to help our kids as parents, we often don't know, and you don't know, what you don't know. They help us emotionally too; they [Aspire staff] are so kind and considerate, so you learn in a safe environment, where you are encouraged and supported (P10).

The emotional support we get for ourselves and kids gives you added strength to deal with what we need to do to help our kids (P14.)

The staff [Aspire] not only show you how to interact with your child, how to support your child, how to support each other, it helps you cope emotionally…parenting can be so demanding. They [Aspire staff] also connect you to other services and places to go with our kids…show us what to do and how to connect with each other, our kids and our community. There is so much I have learnt (P5).

There's different things each week. Different aspects of children's needs that we [parents] focus on…I connect with how he feels…there are things I can do to support how he feels…there are community things to do and I didn't know that before coming here. Not the emotional support stuff or the community stuff (P17).

The staff [an external organisation] didn't understand the importance of emotional support for the parents or child before the Aspire workshop. We all learnt so much about behaviour and child development (OS2).

There were many examples of this theme throughout the interviews, the quotes that directly addressed the theme above. Again, the variety of participants from parents to professionals enhances the robustness and validity of each theme. In the themes above all the participants highlighted the impotence of the modelling of appropriate and productive forms of relating to children and changing children's behaviours. In many instances the parents spoke of profound changes and improvements in their ability to function as a parent, relate to their child and gain confidence. The mothers also acknowledged in the improvements in connections to other services and their ability to connect to the services they and their children needed.

The programs use a range of referral pathways to other professionals to provide inter-disciplinary, and holistic, family interventions. These types of initiatives are important as it connects the programs with the isolated families and prepares the family and child for integrations into the health, education and social systems.

Theme 6: Professional education workshops

The Aspire Child Development and Wellbeing program provides ongoing education for other professionals in a series of workshops held through the year for Health, Human Series and Education Professionals. These workshops help rural professionals in maintaining knowledge and skill development required for professional accreditation and for working with children in the local area (see Appendix C). The staff in this area do not have access to high quietly education and training to advance their skills to enable them to deal with the complex issues faced by modern rural families. The aim of the Aspire program to deliver a flexible and responsive program that addresses the needs of children and families in the Murraylands area is directly addressed through the successful provision of the education and training workshops for other professionals in the area and this is captured in the quotation below:

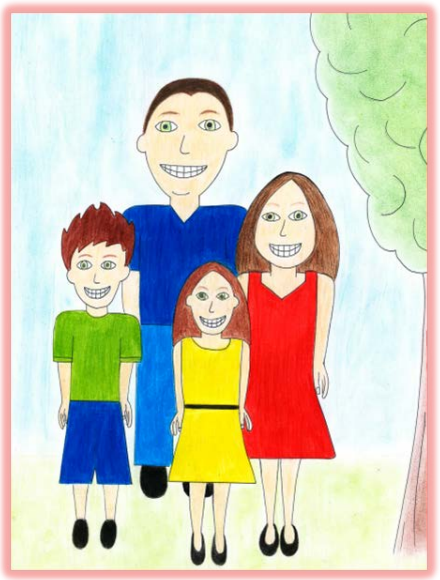
> *We have great difficult in releasing our staff to attend programs in Adelaide. It's a 2 hour drive and then if they are there all day, it's an OHS risk for them to drive home, so they need to stay overnight. It's a costly exercise, the time, the loss of staff hours, the cost of travel and accommodation. The Aspire education programs are fantastic and contain so much useful information and practical strategies to use with very difficult clients. The knowledge and information is also very specific to our area as well. They [Aspire staff] know the area and that is really important…we have 'experts' come in from the department and quite frankly they have no idea…the sessions are useless, it's a waste of time for the staff (OS1, 2, 3).*
>
> *The Aspire program education sessions are focused on this area…the generic application of theories for child behavioural problems don't work here…it's not one size fits all. We need referral pathways that are specific to this area. The Aspire professional educational program directly address our needs. We need it more often – that my only complaint. It's a really important deficit in professional practice if you can't get the appropriate training and education your staff need so we need more education from the Aspire staff not less (OS1, 2, 3).*
>
> *Our staff have learnt so much from the session run by the Aspire staff, Cathy and Melanie, and this surprised them, as they [other service staff] thought they knew a lot, you know, about how to recognises problem behaviour, and how to deal with parents, but Cathy and Melanie taught them so much. We were all very surprised, happily surprised we would like to send our staff to more of these sessions (CP1,2,3 and OS1, 2, 3).*

The quotes above illustrate the importance of informed therapeutic practices being disseminated in a rural area. The quantitative results are presented in figure 4.1. The ability of external professional staff to attend an area specific and intervention, which is theoretically and practically based, and links education session participants to appropriate local services and programs that are therapeutic, is fundamental to Aspires' success. It also ensures the Aspire Child Development and Wellbeing program meets it's aims. The building of knowledge and skills in the local workforce providing services to disadvantage families is crucial if the outcomes for children are going to improve and seen as fundamental by the Aspire staff.

Summary

The themes discussed above occurred frequently throughout the transcripts analysed. The transcripts were independently reviewed and themes compared by the researchers and literature. This ensured an inductive and deductive research procedure and methods was applied to the transcript analysis. The themes illustrate that the community partners, external other service staff, and parents were unanimous in their support of the program, the uniqueness of the program and its ability to meet the needs of the children and improve their child behaviours and interpersonal relationships. Many professional external staff spoke of the fundamental and unique, support and knowledge, provided by the Aspire staff along with the critical success of the interventions the Aspire Child Development and Wellbeing program provides as making 'a profound and important impact on the children and families' involved with their service.

The program targets children and parents with difficult behaviours, and learning and language deficits in a manner that facilitates learning and engagement with the materials provided. The comparison of the materials provided (see appendices) and the themes from several sources and perspectives provides an internal validity for the themes, and research robustness, for the research design, processes used and the research findings. The Aspire program provides a high quality interventions and the necessary referrals; supports, professional practices, and modelling and behavioural interventions that reduce the risk for children in failing at kindy and school along with improving support of the families and empowering families to make changes to address problem behaviours. The importance of these interventions cannot be over stated for the children and families involved. These findings are repeated throughout the results section of this report.



Section five:

Discussions and conclusions

Introduction

As stated in the introduction it is well established in the Early Child Development (ECD) that for infants, children, and adults to succeed educationally, socially, and psychologically, and participate as productive members of a family, community and society, then participation in well-conceived and evidence-based high quality ECD programs is paramount. The research indicates stark differences between those who participate in well-conceived ECD programs as successful learners in kindergarten, primary, secondary and tertiary education (Mustard 2006, DoCS 2009, Dockery, Grath et al. 2010, Mustard 2010, Reynolds, Temple et al. 2011). On the whole young children who participate in high quality ECD programs are more competent socially and emotionally, and show higher verbal and intellectual development (Mustard 2006, DoCS 2009, Dockery, Grath et al. 2010, Mustard 2010, Reynolds, Temple et al. 2011). The Aspire Child Development and Wellbeing program provides child development

knowledge, such as the importance of play, language, structure and activities for children's learning. Developmental knowledge assists the parents in providing a home environment that aids child learning and safe development. Neurobiological and brain development information is also given to the parents. This can aid in the understanding of children's behaviour and needs.

The use of the activities is specially designed to:

- improve the child/parent interpersonal relationship
- increase the child's social and empathic development
- increase positive reading and language development
- increase the adult's knowledge of child development
- improve and increase the provision of age appropriate play, pretend play and activities
- address some aspects of obesity through increased physical activities
- improve a sense of self-worth of the parents
- enhance attachment
- provide purposeful and well-constructed activities that meet the children's developmental milestones such as fine and gross motor skills.
- model exemplary parenting and attachment behaviours
- provided one on one support for parents having difficulties with parenting skills.

These aims/goals of the Aspire Child Development and Wellbeing program have been achieved according to the literature evidence-base, data, findings, and research outcomes, provided in the previous sections. The participants outlined the positive changes that had occurred as a direct result of attending the Aspire Child Development and Wellbeing program and/or the Aspire education and training sessions.

The quotations above highlight the use of developmental information and behavioural strategies to improve; children's behaviour, language, ability to engage in leaning activities, and the interactions in the child/parent relationships. It connects the parents with information about child development, language, and socialisation that is delivered in a manner that promotes parental uptake and implementation.

All of the community partners, external services staff, Aspire managers and staff, and parents have discussed the Aspire Child Development and Wellbeing program with a great deal of positivity. Particularly when questioned on the notion that the mothers and young children

attending the program activities now had a set of strategies which assisted them in supporting their children's development, education and health. All the participants explained the strategies in detail and the stated how these strategies had improved outcomes for themselves and their families.

The intensive supported provided in the Aspire Child Development and Wellbeing program assisted by the supportive learning environments and activities based on the interpersonal relationships, child development, and mindfulness skills that enhance language development, motor and cognitive skills through play, balancing and team building. Additionally, the managers and staff modelled appropriate child engagement behaviours and strategies for the mother to use at home. Furthermore, the Aspire staff provided one-on-one sessions for parents who appeared to be distressed or struggling thereby circumventing future parenting problems and providing a strengths-based approach to parental skill development.

There was a great deal of discussion on the need for the program to continue. Given the uniqueness of the program and its outstanding involvement of disadvantaged families. This outcome is also maintained by the literature. Furthermore, the research has outlined that only evidence based therapeutic prevention and intervention program improves the levels of family functioning that are equivalent to this program outcome.

Furthermore, the success of the Aspire Child Development and Wellbeing is the whole community approach to family problems and issues. This is evident by the connection to other service providers, and the delivery of knowledge, education and training to other service providers, such as family day care, Minya Porlar Crèche (an Aboriginal Crèche). Further, in the addressing of trauma and mental health problems. The use of this theoretically based preventions and interventions along with the structured educational and developmentally based activities provides the broader family supported needed to address complex child behaviour problems, such as bedwetting, toilet training, language development, and home environmental issues, such as exposure to trauma, domestic violence and sexual abuse. The use of one type of intervention e.g. BUGK without Hanen would results in a program seriously lacking in the number of elements used in this program and would arguably be unsuccessful.

Further, the changes evident in the parenting and child's behaviour support the use of theoretical bases for the program interventions and program models used. These models and therapeutic intervention practices are well researched, and established as best practice. The use of quantitative measures has enhanced the evidence for the positive outcomes delivered by these programs.

The use of Hanen, Attachment Theory, Circle of Security, and BUGK, ensures that the changes in parents and children are consistent and standardised due to the use of validated and reliable intervention techniques and practices. The use of staff trained to deliver consistent intervention is central to the success of the program.

Furthermore, given the vulnerability of the target populations attending, the stability of the staff has also enhanced the use of this program. Vulnerable populations can present as difficult to engage, however, the staff have successfully gained the support of the community and the target participants.

Limitations

This evaluation research is limited as the results are specific to the Aspire Child Development and Wellbeing program used in the Murraylands area. Also, fathers were not interviewed or present in any of the focus groups. The mothers interviewed did express a need for a Saturday session occasionally that could include dads, so this may need to be addressed. The program would benefit from a data collection process that included a dosage result that would enhance correlational analysis.

The data collected in the professional staff education and training sessions needs to provide more options than an 'agree, disagree and don't know'. The use of a Likert scale would provide a wider variety of responses that could be used to provide useful data for inferential statistics.

Conclusion

The current Aspire Child Development and Wellbeing program, commencing in 2014, uses several evidence-based complementary foundational theories to deliver a unique program that addresses the needs of this rural community with higher than average levels of childhood vulnerability. The theoretically, evidence-based interventions are successful and this is

supported by the numbers of main themes found within the data that discuss the importance of the program and the difference it has made to; how the parents relate to their children, the improvements in the child's behaviour, and school readiness. It is also evident from the interviews and focus group data provided, that this would not have occurred without this program, and the children would remain exposed to unacceptably high levels of vulnerability, which would impact on their schooling, and their ability to learn. The success of the theoretically substantiated and evidence based programs has been enhanced by the delivery of highly qualified staff, who are well connected with the target population.

The responses from the service staff that attend the staff only sessions indicated that the programs provided informed and educated the staff in the needs of vulnerable children and parents. The programs provided by the Aspire staff remain true to the evidence-base of the interventions from the theoretical and practical application perspectives. This process adheres to the CfC aims and the use of interprofessional and multi-professional services that directly address the recent theoretical advances that challenge the use of singular interventions and developmental theories.

The use of theoretical and therapeutic based protocols is paramount to the success of the Aspire Child Development and Wellbeing program. The development of the program since 2014 has included the responsiveness of the professional staff required to change the program meet the needs of parents in disadvantaged families. The inclusion of programs that train local professional staff has enhanced the reach of the knowledge provided by the Aspire staff. For example, the 'Helping Children with Motor Difficulties Session' (see appendices) is aimed directly at staff in other services and provides them with the skills to recognise a child with motor development issues. Without this training these issues in the local community would be missed and the impact of the child's development would be profound and lifelong.

The caring and inclusive attitudes and responsiveness of the Aspire managers and staff promote and atmosphere of acceptance and support thereby promoting attendance of this vulnerable child population and ensuring the myriad of positive experiences provided through the Aspire Child Development and Wellbeing sessions. The ongoing success of this program relies on the ongoing funding of the CfC initiative.

The previous research outlined in the literature review section clearly states that the use of complementary programs that address several child behaviours are more successful with complex and difficult to engage families. Programs that may address one distinct behaviour that are delivered over strict timelines often do not meet the needs of the most at risk children and families. The use of a program that directly addresses the needs of the families, such as the Aspire Child Development and Wellbeing program are more suited to complex and isolated families, such as those in the Murraylands Rural Region.

The importance of children emotional competence, cognitive, language and psychological development is assisted by positive evidenced-based parenting, playgroup, and crèche programs. Children's success in school is also based on children's social adjustment. The Aspire Child Development and Wellbeing program provide interventions that are successful and evidence-based in aiding children's social, emotional, physical, psychological and educational development. Also the ac.care programs of which Aspire Child Development and Wellbeing is the one assessed here, build parental capacity to parent, parental confidence, and decrease child behavioural problems, and parental isolation. These findings are supported by the literature, previous research and this research evaluation project.

The results of this research illustrate the importance of the Aspire Child Development and Wellbeing early intervention programs in engaging with parents and changing the behaviour of parents, and children, that results in, a decrease in the levels of developmental vulnerably and risk for the children attending the programs. The information from the in-depth interviews, observation data (Goal Achievement Tool), and focus groups supported the evidence that there had been sustained change in how the parents respond to their children, and an increased capacity in the parent's ability to meet their children's needs.

The methods used to collect the data have informed and enhanced the use of different types of analysis. This process has further validated the results and provided evidence that is substantiated and corroborated from many sources. The similarities in the themes, were consistent across all types of data collection. This is testament to the use of theoretically based, and evidence based interventions, and methods of working with at risk families and children. Additionally, the use of multiple informants and key stakeholders has provided a

circular process that ensures triangulation and robustness of all data collection and the research process.

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Appendix A Program Manual

Program Manual

For

Aspire Child Development and Wellbeing

This manual is a guide to the operations of Aspire Child Development and Wellbeing with parents / carers and their children. The program provides opportunity for parents to learn new social and emotional skills in working with their children. Discussions with parents/carers about parenting will follow some of the information from the Foundational Principles listed theories and programs.

June 2016

Aspire Child Development and Wellbeing Session

- Program facilitated by an Occupational Therapist and a Speech Pathologist.

Aims

- Learn the skill of emotion coaching to improve relationships.
- Introduce a greater understanding of child development.
- Improve communication and positive influences on relationships.
- Learn appropriate responses to child's needs.
- Provide a safe environment for learning and positive nurturing.
- Increase knowledge on how to have better family relationships.
- Encouragement of appropriate support and bonding with the child.
- Reflection on parents own child hood experiences and needs and how to support their own child's needs with self-reflection.
- Role modelling appropriate behaviour from the Aspire Child Development and Wellbeing instructor (worker) to parent/carer and child.
- Group peer support and social buffering.
- Build confidence in managing difficult circumstances and managing risk in the environment.
- Appreciation of the mindful relationship to self, others and environment.
- No cost activity relieving the financial burden of participating in a supported specialised activity.
- Support decision making skills between parent /carer and child.
- Encourage a physically healthy lifestyle.
- Explore choice and consequence while Aspire Child Development and Wellbeing protected waters.
- Learn skills around risk management.
- Increase motor skills and coordination.

Foundational Principles

- Evidence Based Programs information incorporated in session discussions
- Child centred practise
- Attachment Theory
- Child Development
- Circle of Security
- Bringing up Great Kids

- Tuning In To Kids
- Positive Parenting Program

Founding Principles

Child-Centered Practice

The core components of a child- centered approach can be identified as being:

- It keeps the child central at all times
- Features specific to childhood must form the foundation for approaches
- The effectiveness of interventions must be in the terms of the outcomes for the child
- The same room must be used each time to promote a sense of belonging
- Persons working with the child must be comfortable to play and be skilled and knowledgeable about establishing report and communication with the child at their level, both physically and verbally
- Interventions are tailored to the child's individual developmental needs
- And the goal of therapy must be the continued growth and development needed for the child to develop adaptive functioning skills.

(Mudaly and Goddard 2006)

Attachment theory and the importance of relationships

The most important aspect of attachment theory is that an infant needs to develop a relationship with at least one primary caregiver for the child's successful social and emotional development, and in particular for learning how to effectively regulate their feelings and emotions. Fathers or any other individuals, are equally likely to become principal attachment figures if they provide most of the child care and related social interaction. In the presence of a sensitive and responsive caregiver, the infant will use the caregiver as a "safe base" from which to explore.

John Bowlby (1958) "the Nature of the Child's Tie to his Mother".

Harry Harlow (1958) "the Nature of Love".

Trauma-Informed Principles

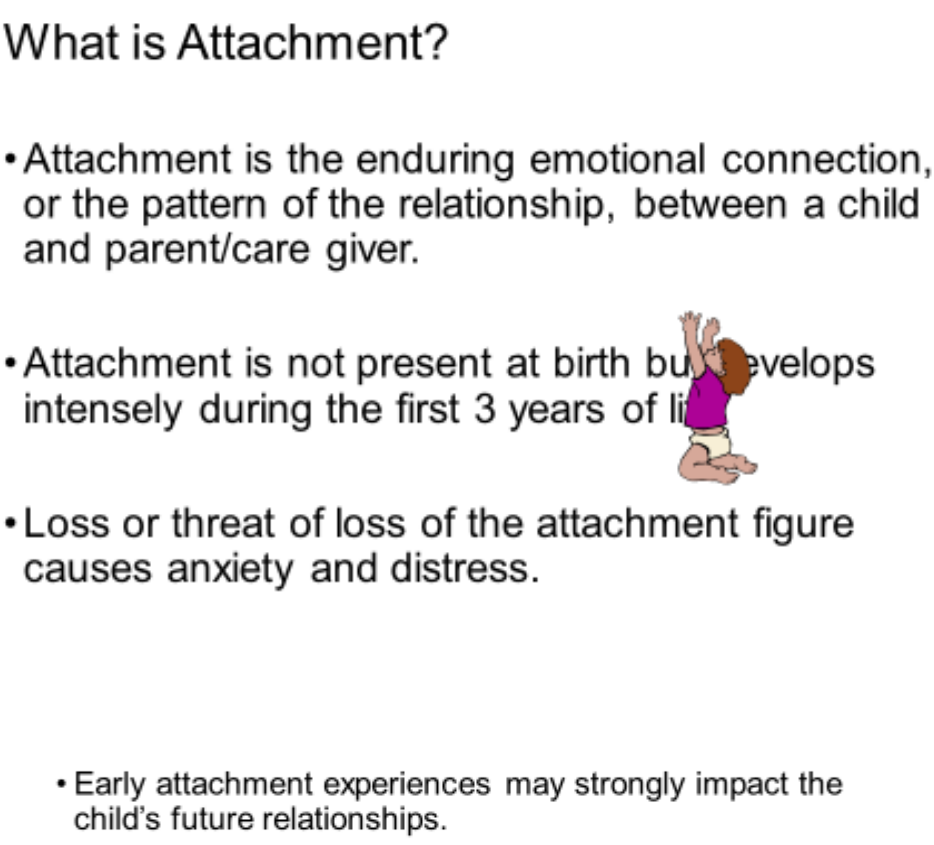
Parents and carers may benefit from understanding that traumatised children are likely to find it difficult to utilise reasoning and logic to modify their behavior or reactions. These children are also unlikely to learn from consequences, particularly when they are in heightened arousal states. It is possible to support parents and carers to avoid the frustration associated with the failure of traditional parenting approaches by increasing their knowledge of trauma. If they understand that trauma acts to scramble cortical functioning and reduce children's capacity to be guided by rule based frames of behavior, they will be less likely to rely on such parenting methods. In addition, children's recovery from trauma will be enhanced through interactions with parents and carers which promote physical activity that stimulates lower order parts of the brain responsible for movement, play and balance. (ACF 2013. www.childhood.org.au) June 30, 2016).

Australian Childhood Foundation (2013) information highlights Key Trauma Intervention principles to be:

- Safety- to offer a 'felt' sense of safety to the child

- Relational
- Flexible, predictable, consistent and repetitive
- Child focused
- Trauma informed
- Recognise sequential development
- Purposeful
- Child able to meaningfully participate
- Focused towards attentional focus
- To work toward mediating physiological arousal levels

Appendix B: Attachment Theory and Circle of Security

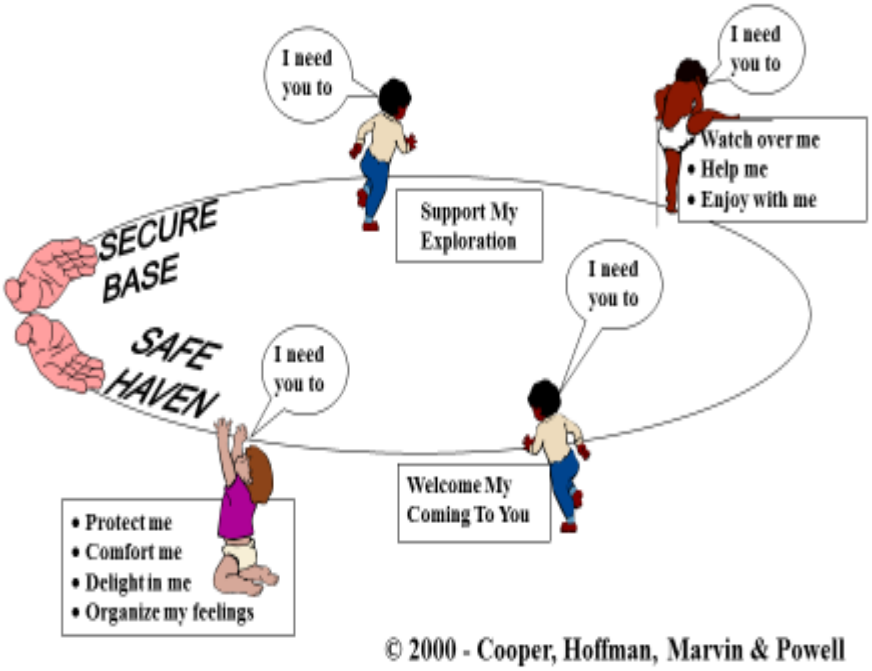


Attachment Impacts on a Child's Development of:

- Trust
- Ability to form relationships
- Exploring skills
- Self-regulation
- Identity formation
- Moral framework
- Core belief system
- Defense against stress and trauma
- Physical health and growth

Circle of Security

Parent Attending to the Child's Needs



Appendix C Example Workshops for Professionals

Workshops that have taken place 2011

Aboriginal Creche Staff and Children

Workshops: Minya Porlar Aboriginal Child Care – OT Support	17 Ab or TSI children aged under 5, 6 with identified dev delays/disabilities, 4 Childcare staff	5 sessions, 2hrs per session	Provided opportunities for the children to participate in play based learning activities with a particular focus for those children aged over 3yrs on skills relevant to getting prepared to enter schooling settings eg transitioning between active outside physical activities and quieter indoor structured activities, listening skills, engaging in an activity to completion, sitting at table and participating in fine motor activities, sharing and turn taking between peers. All the children were keen to participate in the activities with many requests to continue the sessions into the follow-on mealtime! Provided support, ideas and modelling to staff at the centre.
Workshops: Anxiety & Building Self Esteem in Children – Callington and Mannum	20 Adults, 8 children under 5 years old, 3 children between 5 – 12. 2 Staff Capacity Building	2 session, 2 hours	Although aimed at children, this session also helped parents to identify their own anxieties and they were able to explore strategies for dealing with their anxiety and that of their children. This work shop took place at Callington Kindy.

Work shop took place for Family Day Care Providers

Workshops: Active Play – Family Day Care Session - Session for childcare workers - to support them in working with children around development	15 staff for community capacity building	1 session, 2 hours	Session for family day care providers and centre based child care workers. Requested by and supported by family day care field worker. Semi-formal workshop with PowerPoint and discussion. Looked at children's motor development, active play and how to promote in childcare environment. Also, discussed referral options. Written feedback was very positive

Workshops: Toilet Training Information session at LTG. Sessions took place at Learning Together Murray Bridge	7 parents, 5 children, 1 3rd yr OT student, 1 LTG staff member	1 session 2.5 hrs	Parents whose children were about to go through toilet training all indicated they felt much more confident to travel the journey of toilet training with their children. Those parents who have had older children go through the process could support these 'first-time' parents during the session as well as indicating some of the challenges they faced during their first toilet-training experience have now been clearly explained and they too now feel more confident to face the process again.

Workshops: Sleep Matters - Session for families - around issues of their children's sleep	18 parents and 25 children. 1 CALD parent, 1 CALD child, 1 Dad	4 sessions, 1 in each community	Sessions took variable format depending on the group. Three sessions were run during other regularly run programs, these were more informal and only those parents who were interested or concerned joined the conversation. The other session was a standalone session and was a more formal workshop. Written feedback was obtained from3 of the sessions and was positive. Parents took information booklets home as resources. Parents enjoyed the opportunity to discuss their individual experiences and feeling supported "hearing that it is common, that I am not the only one going through it". Sessions for parents.

Parenting Programs: Orientation for "It Takes Two to Talk" Hanen Program for Parents.	10 Adults, 8 children aged under 5, 1 Aboriginal or TSI child. 7 children with a disability, 1 Dad and 7 Mum's. 2 young parents, 2 grandparents and 1 non-	1 session, 3 hours.	Provide parents with information about the Hanen centre, philosophy and approach. Information about related speech and language services provided by MMCHS. Information about the It Takes Two to Talk program how it can help your child, the importance of the time commitment with being involved in this program and the use of videoing and it's effectiveness as a learning

	related carer. There were 2 child protection children and 5 referred by other agencies.		tool. An opportunity to meet other parents who may be sharing a similar experience. An orientation package that included written information was prepared and given to each family invited to the session. Parent session on communication.

Parenting sessions taking place in 2012

a.	**Title of activity**	**Sleepwise**	
b.	Type of Activity (please select *only one* & delete those that do not apply)	Parenting/family skills training	
c.	In which suburbs, towns or communities was this activity delivered (please delete those that do not apply)	Murray Bridge	
d.	With which FSP Performance Framework Objective/s does this activity align? (please select a *maximum of 3* & delete those that do not apply)	Improve family functioning Improved family's knowledge and skills for life and learning Supporting families and parents – support parents to provide stable environments for children	
e.	Total clients this reporting period.	7 adults and 9 children	
f.	Was this activity limited to clients from a particular demographic group/s?	No	
g	If you answered yes to f.	Demographic Group/s targeted *List up to three from list below:*	Number of clients from this demographic group
	1	Children 0-5	9
	2		
	3		
	Outcomes		
h	What outcomes has this activity achieved? (Provide an outcome statement only and *limit to 300 characters*)	Increased knowledge of sleep patterns and strategies to improve sleep practices. Increased parent confidence to manage sleep issues and improved family well-being.	
i	With which FSP Outcomes does this activity align? (Please select *only one* from list provided & delete those that do not apply)	Children and families have the knowledge and skills for life and learning	
j	How was the activity delivered. (Provide any additional comments about the activity here and *limit to 2,000 characters*)	This program was delivered in collaboration with Disability Services and Learning Together program. It is a 3 x 2hr session program developed by an Occupational Therapist from Disability SA and aims to improve parent's knowledge of normal sleep, sleep difficulties and positive sleep practices. It helps parents to observe their child's sleep patterns and develop a plan to improve sleep, choosing from a wide variety of strategies. Although developed for disabled clients it is equally applicable to the general population struggling to develop good sleep patterns with their children. The sessions included written information and PowerPoint slides but are very interactive	

		and give families a chance to discuss their own situation and gain support and ideas from others. A total of 6 parents/ carers were involved in these sessions although not all attended all sessions. 2 attended the first session and did not return. Both had received some of the information in the program individually and for a variety of reasons did not feel attending all sessions would be useful at that stage. One Mum with an intellectual disability attended the second session but the information was probably in too complex a form in this session and her needs are better met individually. Hence 3 parents were the main participants in the program. Feedback from these families was very positive. One is a foster carer to 2 Aboriginal disabled children who have long term sleep issues. She has tried many strategies, but feels she has new ideas to try and will be supported by the Disability worker involved in the program to follow these through at an appropriate time for the family. One mum reported that "I really enjoyed the workshops and our son is now going to sleep on his own and sleeping all night through- thankyou". In reflecting on the workshops, we feel that for the typically developing population 2 workshops would probably be sufficient, better paced (have had some feedback it can be too slow) and be an easier commitment for families. Being a regional community, we would continue to run a workshop for parents of disabled and non-disabled children together but provide the extra support for the families of disabled children outside the group setting.

a.	**Title of activity**	**'Play Picnic – for Children with Food Fussiness' programme**	
b.	Type of Activity (please select *only one* & delete those that do not apply)	Health & nutrition awareness/support	
c.	In which suburbs, towns or communities was this activity delivered (please delete those that do not apply)	Callington Murray Bridge	
d.	With which FSP Performance Framework Objective/s does this activity align? (please select a *maximum of 3* & delete those that do not apply)	Improve family functioning Improved family's knowledge and skills for life and learning Healthy young families – supporting parents to care for their children	
e.	Total clients this reporting period.	5 adults and 4 children	
f.	Was this activity limited to clients from a particular demographic group/s?	No	
g	If you answered yes to f.	Demographic Group/s targeted *List up to three from list below:*	Number of clients from this demographic group
	1		
	2		
	3		
	Outcomes		
h	What outcomes has this activity achieved? (Provide an outcome statement only and *limit to 300 characters*)	Increased parent/carer awareness and understanding of children's development of food preferences. Strategies for parents of how to introduce new foods to children. Linking of parents who have experienced similar issues with their child's food acceptance journey. Children tasting and exploring foods previously rejected.	
i	With which FSP Outcomes does this activity align? (Please select *only one* from list	Children and families have the knowledge and skills for life and learning	

	provided & delete those that do not apply)	
j	How was the activity delivered. (Provide any additional comments about the activity here and *limit to 2,000 characters*)	A 5 week program comprised of an initial parent information session about how children learn to tolerate new foods, how some of their food acceptance behaviours are influenced by sensory preferences and how to present new foods to children using strategies to help promote active participation and acceptance, followed by four 1wk Play Picnic Play sessions for children, based on the Child Development principles that children learn best through play and fun, where the parents were able to experience observing their children playing with and exploring foods they had previously rejected. The final 3 weeks of the programme were relocated from Callington to Murray Bridge to reduce travel time and distances for participants. This program contributed to a process of weaning one child off tube feeds onto total oral nutrition. For another child who was very under-weight, family anxiety was a significant factor and they were better able to understand this and work through it. The child increased her intake and variety of foods accepted but it also had positive impact on general well-being and family relationships. Another mum increased her confidence in how to support the diet of her child with autism.

a.	**Title of activity**	**Bringing up great kids- Tinyeri children's centre**	
b.	Type of Activity (please select *only one* & delete those that do not apply)	Parenting/family skills training	
c.	In which suburbs, towns or communities was this activity delivered (please delete those that do not apply)	Murray Bridge	
d.	With which FSP Performance Framework Objective/s does this activity align? (please select a *maximum of 3* & delete those that do not apply)	Improve family functioning Improved family's knowledge and skills for life and learning Supporting families and parents – support parents to provide stable environments for children	
e.	Total clients this reporting period.	10 adults and 8children	
f.	Was this activity limited to clients from a particular demographic group/s?	No	
g	If you answered yes to f.	Demographic Group/s targeted *List up to three from list below:*	Number of clients from this demographic group
	1		
	2		
	3		
	Outcomes		
h	What outcomes has this activity achieved? (Provide an outcome statement only and *limit to 300 characters*)	Parents reflected positive feedback about the program and its impact on their parenting and ability to reflect on this and respond to their children	
i	With which FSP Outcomes does this activity align? (Please select *only one* from list provided & delete those that do not apply)	Families function well in nurturing and safe environments	

j	How was the activity delivered. (Provide any additional comments about the activity here and *limit to 2,000 characters*)	This 6 session parenting program was run by Centacare at Tinyeri children's centre. Pathways for families collaborated by providing a crèche for children, integrated with the centres occasional care program.

a.	**Title of activity**	**Our time /Bringing up Great kids**	
b.	Type of Activity (please select *only one* & delete those that do not apply)	Playgroup – (our time) Parenting/family skills training (Bringing up great kids)	
c.	In which suburbs, towns or communities was this activity delivered (please delete those that do not apply)	Tailem Bend	
d.	With which FSP Performance Framework Objective/s does this activity align? (please select a *maximum of 3* & delete those that do not apply)	Our time • Improved the client's access to and engagement with support services • Ensure parents and children have increased connections & social networks Bringing up great kids • Improve family functioning • Supporting families and parents – support parents to provide stable environments for children • Early learning and care – incl. identification and support for developmental/behavioural issues	
e.	Total clients this reporting period.	14 adults and 10 children	
f.	Was this activity limited to clients from a particular demographic group/s?	No	
g	If you answered yes to f.	Demographic Group/s targeted *List up to three from list below:*	Number of clients from this demographic group
	1		
	2		
	3		
	Outcomes		
h	What outcomes has this activity achieved? (Provide an outcome statement only and *limit to 300 characters*)	Parents are better connected to each other, their community and support agencies. Parents have improved parenting skills and reflective abilities. Children have a wider variety of play and social experiences in a supported environment.	
i	With which FSP Outcomes does this activity align? (Please select *only one* from list provided & delete those that do not apply)	Focus on vulnerable and disadvantaged families and children Provide integrated services in collaboration with other services and the community	
j	How was the activity delivered? (Provide any additional comments about the activity here and *limit to 2,000 characters*)	Our time ran as a weekly program during term time over both terms. This is an informal supported group for parents and children and has been running for several years. A C4C funded health support worker attended weekly with support approximately fortnightly from a social worker (not C4C funded). Parents attending 'Our time' previously gathered informally to share their experiences of family life and parenthood. The group had little structure and was open to any parent. This term the group expressed an interest in participating in a more formal parenting program to support them in their roles as parents. The parenting program used ideas of mindfulness and reflection to support parents to	

		review and enhance their understanding of children's development and their relationship with their children. Parents had the option to attend a parenting program (Bringing up great kids) being delivered in the same venue but in a different room, or to remain in the space Our Time usually meets. The parenting program was a closed group based on a 12 hour program delivered in partnership with Centacare's "walking together" program in a six week x 2 hour session. Most parents attended with their children who were all under 5 yrs of age. Other parents had children of school age. One parent came from a more remote part of the region, where there is reduced population and services making the family more isolated. One 'couple' (mother and father) attended the sessions.

	Deliverables		
k	In reviewing services delivered by this activity, how many of the deliverables are being met? (Select *only one* from list)	All	
l	Were there challenges in meeting the deliverables?	Yes	
	If yes, describe how they were overcome (*limit of 2,000 characters*)	In several programs there were challenges due to the irregular attendance of group members. This meant some adaptation of programs at the time, which was made possible by having more than one facilitator. The play picnic program was run at Callington due to expressed interest from the community. It was moved back to Murray Bridge as most participants were not from Callington and were travelling further as a result. Some Callington residents attended the information session and this seemed to meet their needs and they did not continue to attend. This has led to the intention to run introduction sessions for several programs around the region, to then feed into a main program in Murray Bridge. This acknowledges that parents are looking for different levels of information/ support around key issues.	
m	Which deliverables have *not* been met and why? Please provide details below. *(Copy and paste additional lines if required)*		
	Deliverable not met (as outlined in AWP)	Reasons why the deliverable could not be achieved (*limit approx. 200 words*)	Plans to meet the deliverable (*limit approx. 200 words*)
	Refer AWP for details	Limit to approx. 200 words	Limit to approx. 200 words

Service Activity 3: Capacity building for staff in education and care sectors

a.	**Title of activity**	**"Play Picnic – Fun with Food"** **Combined Occupational Therapy State Conference and Country Forum presentation**
b.	Type of Activity (please select *only one* & delete those that do not apply)	Professional training/development
c.	In which suburbs, towns or communities was this activity delivered (please delete those that do not apply)	Murray Bridge

d.	With which FSP Performance Framework Objective/s does this activity align? (please select a *maximum of 3* & delete those that do not apply)	Provide services that satisfies the client's needs Link early childhood services with other Commonwealth services Healthy young families – supporting parents to care for their children	
e.	Total clients this reporting period.	25	
f.	Was this activity limited to clients from a particular demographic group/s?	Yes	
g	If you answered yes to f.	Demographic Group/s targeted *List up to three from list below:*	Number of clients from this demographic group
	1	Early childhood professionals	25
	2		
	3		
	Outcomes		
h	What outcomes has this activity achieved? (Provide an outcome statement only and *limit to 300 characters*)	Education of Statewide Allied Health Early Childhood Professionals (Occupational Therapists) about evidenced outcomes arising from conducting Play Picnic programs for parents and carers of children with Food Fussiness across the Murray Mallee Region. Further presentations have been conducted at Early Childhood work sites following requests from interested participants	
i	With which FSP Outcomes does this activity align? (Please select *only one* from list provided & delete those that do not apply)	Provide integrated services in collaboration with other services and the community	
j	How was the activity delivered. (Provide any additional comments about the activity here and *limit to 2,000 characters*)	Joint presentation by MMCHS OT and SP at State based Occupational Therapy Conference held in Murray Bridge presenting information about the Parent /Carer Play Picnic Programs conducted by MMCHS OT and SP in Feb 2012 and Aug 2011 within the Murray Mallee region. The procedures followed, the format undertaken and the evidence arising from formal feedback and evaluations were presented. Further Statewide Early Childhood Professional linkages have been created following this presentation due to participants seeking further information.	

a.	**Title of activity**	**'Viewing Classroom Behaviours through a Sensory Lens' Combined Occupational Therapy State Conference and Country Forum presentation**
b.	Type of Activity (please select *only one* & delete those that do not apply)	Professional training/development
c.	In which suburbs, towns or communities was this activity delivered (please delete those that do not apply)	Murray Bridge
d.	With which FSP Performance Framework Objective/s does this activity align? (please select a *maximum of 3* & delete those that do not apply)	Improved the client's access to and engagement with support services Link early childhood services with other Commonwealth services Early learning and care – incl. identification and support for developmental/behavioural issues
e.	Total clients this reporting period.	50

f.	Was this activity limited to clients from a particular demographic group/s?	Yes	
g	If you answered yes to f.	Demographic Group/s targeted *List up to three from list below:*	Number of clients from this demographic group
	1	Early childhood professionals	50
	2		
	3		
	Outcomes		
h	What outcomes has this activity achieved? (Provide an outcome statement only and *limit to 300 characters*)	Linking of Health and Education agencies as partners in presentation. Education of Statewide Allied Health Early Childhood Professionals (Occupational Therapists) about evidenced outcomes arising from conducting these workshops for Early Childhood workers across Murray Mallee Region.	
i	With which FSP Outcomes does this activity align? (Please select *only one* from list provided & delete those that do not apply)	Provide integrated services in collaboration with other services and the community	
j	How was the activity delivered. (Provide any additional comments about the activity here and *limit to 2,000 characters*)	Partnered presentation at State based Occupational Therapy Conference held in Murray Bridge presenting information about the Early Childhood Worker workshops titled "Understanding Sensory Processing and how it influences children's behaviours" conducted in May 2012 and Sept 2011 within the Murray Mallee region. The procedures followed, the format undertaken and the evidence arising from formal feedback and evaluations were presented. Further Statewide early Childhood Professional linkages have been created following this presentation due to participants seeking further information.	

	Deliverables		
k	In reviewing services delivered by this activity, how many of the deliverables are being met? (Select *only one* from list)	Some	
l	Were there challenges in meeting the deliverables?	Coordinating appropriate times for sessions- see below.	
	If yes, describe how they were overcome (*limit of 2,000 characters*)		
m	Which deliverables have *not* been met and why? Please provide details below. *(Copy and paste additional lines if required)*		
	Deliverable not met (as outlined in AWP)	Reasons why the deliverable could not be achieved (*limit approx. 200 words*)	Plans to meet the deliverable (*limit approx. 200 words*)
	Workshops and capacity building sessions for staff, especially in child care and education	Although there were several opportunities for staff to present their work to other professionals at conferences, broadening the influence of programs and creating good links, local sessions for staff of other agencies did not progress this 6 months. In particular there have been on-going efforts to link with staff from the 24 hr houses for guardianship children, but a	We are working to reschedule these sessions.

		date has been difficult to set. In addition a session "learning the skills for active play" for child care workers had to be cancelled and will be rescheduled.	

Just one of our Activity Work plans developed when in Partnership with Murray Mallee Community Health

Aspire was developed after conversations with Cathy and Melanie and myself as Health were unable to continue as a CP. It was going to be a huge loss for our Community as both ladies were making a huge impact and were the only local professionals working in Early Development in our region that were the experts on this.

We wanted it to continue hence they formed the partnership and to a lessor extend could keep the playgroup in Mannum going. From this Aspire was developed and they have been providing Joining the Dots... since 2014. We want the availability in the evaluation to be able to offer the playgroups as described but also the parenting sessions and the sessions aimed at professionals/service providers working with these children in our community. From the reports above and the AWP below it shows the importance of why and what we are trying to achieve.

Activity Work Plan for: 1st July 2012 to 30th June 2013

Strategy Pathways for Families

Strategy: Pathways for Families

- To create connections and pathways for families, communities and individuals to come together to create stronger communities.
- Early identification, support and education for children at risk of developmental problems and their families

Overall Target Group: *(using the tick boxes below identify from your Community Strategic Plan the overall target group for this strategy. You may tick multiple boxes if the strategy targets multiple family types)*

This strategy meets the needs of:

☑ vulnerable and disadvantaged families
☑ Indigenous families and their children
☑ families impacted by changes to parenting payment eligibility requirements
☑ young parents and jobless families, if applicable

Activity 1

Supporting Activity Name: *(insert the name of the activity you will implement)*
Family Group Support and Informal Education

Activity Description: *(provide a description of the activity you will implement)*

Create strong child-friendly communities by taking a community development approach to support groups already established in the community to continue and develop. Pathways for families is no longer able to provide weekly organisation and facilitation of groups at Tailem Bend "Our time" and Mannum "Little Bugz" but will through *collaborative partnerships* facilitate alternative arrangements and/or transition to more independent function whilst retaining connection, visiting regularly and supporting access to services and resources. This approach has already been taken with Callington and support will continue for this community.

Staff will also continue to visit a variety of groups in the community (including pre-walkers play group, groups above) for informal sessions providing information on request and supporting access to the *universal services available*, *linking* families to resources and providing "soft entry points" to accessing services for children and families especially around their developmental needs.

Activity Objective/s and Outcome/s*: (describe the objective/s and expected outcomes you are seeking to achieve through your activity. In your response you should also indicate which FSP outcome(s) and CfC-FP Objective(s) the activity supports and how)*

The program aims to continue to support community to create connections and pathways for families, communities and individuals to come together to create stronger communities. This meets the CfC objective of *create strong child friendly communities.* It also aims to support parent's understanding of their children's needs and development. support early identification, support and education for children at risk of developmental problems and their families. As such it supports the CfC objectives of *early learning and care* and provides referral pathways that *link universal services with specialist support services* Developing supportive groups in rural communities is important to FSP outcomes- *Families function well in nurturing and safe environments* and *Families, including children, especially those who are vulnerable or disadvantaged, benefit from better social inclusion and reduced disadvantage.*

Milestone/s and Timeframe: *(describe the key elements/milestones of each activity including details of how each activity will be achieved and over what period will it will be delivered)*

Arrangements for Mannum and Tailem bend groups are currently in negotiation phase, such that frequency of involvement is hard to determine. It is likely to start more frequently and decrease over the period. Support for each community (Mannum, Callington and Tailem Bend) will include visit to groups at least 1-2 x term and phone contact linkage with leaders as needed. 1-2 other informal visits per term by therapist s to a variety of groups as requested.

Specific Target Group: *(describe who the specific target group is for the activity and why you have chosen to support this specific target group)*

Parents and children (mainly 0-5) living in the district, especially those in Mannum, Callington and Tailem Bend. These communities being small rural towns have limited access to resources, high rates of poverty, transport disadvantage, domestic violence, and parental mental health.

Collaboration and Service Integration: *(who you will engage and collaborate with to deliver the activity)*

Programs in Callington will be in conjunction with Callington kindergarten and school, learning Together outreach and the Callington community group

Programs in Tailem Bend are in collaboration with the Tailem Bend community centre, Learning Together and other agencies and supported by the Tailem Bend early years network.

Programs in Mannum are in collaboration with the Mannum kindergarten

Programs in Murray Bridge are in collaboration with Learning Together, Tinyeri Children's centre and other community groups as requested

Support for communities generally will also include collaboration with Lutheran Community Care connecting neighbours program

Evaluation: *(describe the approach you will take to assess whether the activity you have committed to is making a difference and how you will evaluate the success of the activity. In your response consider your approach for collecting data including community and client feedback)*

The effectiveness of the Family group support and informal education activity will be measured by the number of parents and carers attending the group sessions. These figures will be captured through attendance records.

Client feedback will also be used to determine the success of the activity. This will be obtained through client surveys which will be conducted 6 monthly and on-going group reviews.

Effective collaboration and service integration will also be measured through referral statistics and discussions with agencies.

Stories of the community groups also provide a qualitative description of community development and will be captured by the local evaluator.

Activity 2

Supporting Activity Name: *(insert the name of the activity you will implement)*

Education Sessions and Programs for Families

Activity Description: *(provide a description of the activity you will implement)*

Supporting families and parents through relationship based programs and information provision addressing children's development. This will included some of the following programs dependant on needs- Hanen- it takes two to talk, Sleep wise, Toilet-time, Play picnics, Bringing up great kids. In a rural context where numbers are sometimes low, many of these programs are useful for parents of children with special needs but also available to a more universal population. Mixing these groups has been successful in helping to break down barriers and share parenting experiences. Many of these programs will be in collaboration with other agencies or located in community venues that families access.

Activity Objective/s and Outcome/s: *(describe the objective/s and expected outcomes you are seeking to achieve through your activity. In your response you should also indicate which FSP outcome(s) and CfC-FP Objective(s) the activity supports and how)*

Families will have increased knowledge and have practical learning experiences that support their children's well-being and development. Many of these programs are very practical and involve supporting changes in families. Hence the FSP outcomes *Children and families have the knowledge and skills for life and learning* and CfC objectives *support families and parents* and *early learning and care will be developed.*

Milestone/s and Timeframe: *(describe the key elements/milestones of each activity including details of how each activity will be achieved and over what period will it will be delivered)*

Programs vary in length and intensity, so depending on community needs which programs will be delivered. Generally there will be a session of one of these programs most weeks during school terms.

Specific Target Group: *(describe who the specific target group is for the activity and why you have chosen to support this specific target group)*

Families with children 0-5, especially those with children with issues impacting on their development and well-being (including developmental delays, disabilities and emotional issues related to family stress or trauma). Many of these families are vulnerable families for a variety of reasons.

Collaboration and Service Integration: *(who you will engage and collaborate with to deliver the activity)*

Programs may be co-facilitated with staff from another agency eg another partner through CfC, Disability services, Tinyeri children's centre or Learning together program and may be provided in the community at a range of venues in collaboration with their programs.
Evaluation: *(describe the approach you will take to assess whether the activity you have committed to is making a difference and how you will evaluate the success of the activity. In your response consider your approach for collecting data including community and client feedback)* The effectiveness of the Education sessions and programs for families activity will be measured by the number of parents and carers attending the group sessions. These figures will be captured through attendance records. Client feedback will also be used to determine the success of the activity. This will be obtained through client surveys which will be conducted at the end of the program and in some instances this may be followed up at a later stage to evaluate family change.

Activity 3

Supporting Activity Name: *(insert the name of the activity you will implement)* Capacity Building for Staff in Education and Care Sectors
Activity Description: *(provide a description of the activity you will implement)* Workshops and capacity building sessions for staff esp in child care and education (esp early years) sectors around topics such as play and development and communication skills. There will also be a focus on sensory approaches to behaviour esp in children who need support to regulate their responses to stress and emotion and to decrease obstacles to engagement for children in learning environments.
Activity Objective/s and Outcome/s*: (describe the objective/s and expected outcomes you are seeking to achieve through your activity. In your response you should also indicate which FSP outcome(s) and CfC-FP Objective(s) the activity supports and how)* Care and education staff will have an improved knowledge of children's development and how to adapt their environment and curriculum for children with developmental and behavioural difficulties. This works towards the CfC objective of *Early learning and care*, and *linking the universal* education and care sectors with the *specialist services* for children with difficulties by raising their awareness of strategies, services. FSP outcome of *Services focus on vulnerable and disadvantaged families and children*, by looking at those children disadvantaged within the universal education and care sectors and *helping organisations provide integrated services and work in collaboration with other services and the community*.
Milestone/s and Timeframe: *(describe the key elements/milestones of each activity including details of how each activity will be achieved and over what period will it will be delivered)* 3-4 workshops during the financial year.
Specific Target Group: *(describe who the specific target group is for the activity and why you have chosen to support this specific target group)* Target group is staff in education and early years education sector but the indirect target group is children in these services with developmental and behavioural difficulties. This includes some children in alternative care placements.
Collaboration and Service Integration: *(who you will engage and collaborate with to deliver the activity)* Collaboration with childcare and education sectors will be needed to connect with their staff education programs. This will include DECD, child care centres and ac care's 24 hour house for children in alternative placement. Collaborators in providing the training will include the DECD behaviour support staff and Ac care collaborative learning project.

Evaluation: *(describe the approach you will take to assess whether the activity you have committed to is making a difference and how you will evaluate the success of the activity. In your response consider your approach for collecting data including community and client feedback)* Participant surveys and attendance records will form the main evaluation of these sessions. Anecdotal feedback about the impact may also me collected in subsequent contact with agencies.

Appendix D – Feedback and Evaluation templates -Workshops for professionals

Communication workshop - Evaluation Sheet - Callington

	 Strongly agree	 Partially agree	 Strongly disagree
I found the information useful	5	2	
The information was presented in an easy to follow format	7		
I felt the session had the right amount of information	7		
I feel I am able to use some of the information with my child	6 Both little people	1	
If I need any further information with understanding how communication affects children, or have any other developmental concerns I know where I can go to get help.	7		
Things I found the most useful from the session were: Milestones and signs to look for concern. Milestones for each age group. Different developmental stages of a child's speech! 18 months to 2 years info.			
I would recommend the following changes to the session format: None. No - Great.			
Any further comments: Well done. Thank you.			

Thankyou for your time to complete this evaluation. Any suggestions will help to improve future presentations

Targeted Education Programs

Is it Time for Toilet Training?

A Toilet Training Information session

- Is your child finding the journey of learning Toilet skills a challenge?
- Are you becoming a bit worried they might not be "trained" in time for kindy?
- Is your child having "accidents" at

communities for children

invites parents of children struggling with learning the skills of Toilet Training to an information session with the Occupational Therapist from Murray Mallee Community Health Service

When:

24th Sept or *3rd Dec*

10.30am - 12.30pm

Where:

Ngagri Wal

25 Joyce St Murray Bridge

Contact (Bookings essential):

Cathy Rice

MMCHS Children & Families Team

☎ 8535 6800

CRECHE available if booked prior

communities for children

ac.care

Communities for Children is funded by the Australian Government Department of Families, Housing, Community Services & Indigenous affairs

Maybe My Child has *Sensory Issues*??

- *Have you heard this and wondered what it means?*
- *Have you wondered why your child struggles to sit still?*
- *Are supermarket trips a trigger for tantrums?*
- *Is your child a 'busy bee' and struggles to play with one thing for very long?*
- *Are mealtimes challenged by your child's food fussiness?*

An Information Session for Parents

about Sensory Processing and how it affects children's behaviours is being held by the Occupational Therapist from Murray Mallee Community Health Service

When:
Thursday 27th June 10.30am —12.30pm

Where:
Ngagri Wal
25 Joyce St Murray Bridge

Contact (Bookings essential):
Cathy Rice
MMCHS Children & Families Team
☎ 8535 6800
CRECHE available if booked prior

Government of South Australia
Department of Education and Children's Services

Session funded by

communities for children

ac.care

Anglican Community Care Inc | ABN 53 440 436 445 | Charity Licence CCP1186
Web: www.accare.org.au | Email: CommunitiesForChildren@accare.org.au
Communities for Children is funded by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs

www.facebook.com/CfCMurraylands

Pre-Walkers Playgroup

Visit from a Physiotherapist

communities for children invites parents of babies to informal information sessions with the physiotherapist from Murray Mallee Community Health Service who will be available to answer questions about:

Baby development and motor skills, children's posture, head shape and footwear and local services to support families

Government of South Australia
Department of Education and Children's Services

Learning Together

communities for children
facilitated in Murray Bridge by ac.care
opportunities for life ... for rural people

When:
Monday Nov 4th 2013
Monday Nov 18th 2013
Monday Dec 2nd 2013

Where:
Murray Bridge Learning Together
Fraser Park Primary School
25-27 Burdekin Avenue

Time:
1pm - 2:30pm during pre-walkers playgroup
Contact:
Children & Families Team ☎ 8535 6680

www.facebook.com/CfCMurraylands

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Web: www.accare.org.au | Email: CommunitiesForChildren@accare.org.au

Communities for Children is funded by the Australian Government Department of Social Services

Appendix E – Goal achievement tool

JOINING THE DOTS GOAL RECORD SHEET

Getting Ready for Kindy Term 4 2016

Name:_____ D of B:_____ Age:_____

	Parent Goal for Child	Current skills	Goal Achieved	Scale	Score
1			YES ❒ NO ❒	Much better than expected ❒ A little better than expected ❒ **As expected ❒** Partially achieved ❒ Same as baseline ❒	+2 +1 **0** -1 -2
2			YES ❒ NO ❒	Much better than expected ❒ A little better than expected ❒ **As expected ❒** Partially achieved ❒ Same as baseline ❒	+2 +1 **0** -1 -2
3			YES ❒ NO ❒	Much better than expected ❒ A little better than expected ❒ **As expected ❒** Partially achieved ❒ Same as baseline ❒	+2 +1 **0** -1 -2
Anything else we need to know:					

adapted from Goal Attainment Scale (GAS)

GOALS: Present Tense, Realistic, Achievable, Measureable, Specific = ***PRAMS***